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## ORIGINAL ARTICLES.

### **SOME POINTS IN THE DIAGNOSIS AND TREATMENT OF INTRA-CEREBRAL HEMORRHAGE AND IN THE TREATMENT OF CHOREA.<sup>1</sup>**

By J. T. ESKRIDGE, M.D.,  
OF DENVER, COL.;

PROFESSOR OF NERVOUS AND MENTAL DISEASES AND MEDICAL JURISPRUDENCE IN THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF COLORADO; NEUROLOGIST AND ALIENIST TO THE ARAPAHOE COUNTY AND THE ST. LUKE'S HOSPITALS.

**INTRA-CEREBRAL HEMORRHAGE.**—Usually the first and most obtrusive symptom of intra-cerebral hemorrhage is apoplexy, or partial or complete loss of consciousness, more or less sudden in onset, and more or less prolonged in duration. In the majority of cases we have added the local or hemiplegic symptoms. In the severer forms of cerebral hemorrhage there is complete relaxation of all the voluntary muscles of the body, including the sphincters of the anus and bladder. In the milder cases there may be only slight obscuration of consciousness; in the severer ones, unconsciousness is profound.

In a typical case of cerebral hemorrhage, ushered in by marked apoplectic symptoms, the patient lies as in a profound sleep, with a tendency to stertorous and labored breathing. The skin is usually bathed in perspiration. The pulse is often full and bounding; sometimes it is small, rapid, and incompressible. The temperature, at first, in all but the milder cases, is lowered from  $0.5^{\circ}$  to  $1^{\circ}$  or  $2^{\circ}$ , but in a few hours it rises from  $0.5^{\circ}$  to  $1^{\circ}$  or more above normal. Immediately after the shock the temperature on the paralyzed side is lower than on the unaffected side, but in a very few hours it is higher on the affected than on the non-affected side. A careful study of the temperature is of considerable importance, both in the diagnosis and prognosis. The face is often flushed, but sometimes it is pale. The urine is at first abundant and of rather low specific gravity, but soon it becomes less abundant and has a high specific gravity. Sometimes it contains albumin, but no tube-casts, unless there is some renal complication. Convulsions are more common in lesions of the cortex; vomiting is most frequently met with in lesions of the cerebellum.

In nearly all cases, except the severer ones, in which there may be complete relaxation of all the

voluntary muscles of the body, there are local, or one-sided, symptoms. The most pronounced of these is the hemiplegia, involving the leg, arm, and face on the same side. In rare instances there is crossed paralysis, with affection of the leg and arm on one side, and of the face on the opposite side. When the hemiplegia is incomplete, the arm is most affected, the leg next, and the face least of all. The distal portions of the extremities are more affected than the proximal. Immediately after the shock the deep reflexes are abolished on both sides. They return first on the unaffected side, but they soon return on the paralyzed side and become more pronounced than in the unaffected limbs. The superficial reflexes not infrequently remain absent on the paralyzed side for several weeks. One pupil may be dilated and fail to respond to light, or both may be dilated or contracted. The eyeballs are usually fixed, and more commonly they deviate to the paralyzed side, although there may be conjugate deviation of the eyes with turning of head toward the unaffected side. The facial paralysis is limited to the lower part of the face, and the affected cheek puffs out during expiration. If the patient is able to protrude the tongue, it deviates toward the paralyzed side. Even when the unconsciousness is profound, the muscles on the affected side are not so completely toneless as those on the unaffected side. The local symptoms vary according to the seat of the hemorrhage.

In a given case of supposed cerebral hemorrhage, during the apoplectic state, the diagnosis has to be made from a similar condition caused by syncope, or by chloral, opium, or alcohol poisoning, or by uremia, epilepsy, hysteria, embolism, thrombosis, the apoplectiform attacks occurring from cerebral congestion or from the cerebral state found in parietic dementia, and from "simple apoplexy" in the aged.

Syncope from cardiac failure is easily distinguished from cerebral hemorrhage. In the former the heart's action is exceedingly weak; the pulse is small, very feeble, and almost imperceptible; the face is blanched; the lips are very pale; respiration is shallow, or it may be sighing and irregular; reflex action is rarely abolished; the sphincters are not relaxed; the pupils are equal and widely dilated, and there are no hemiplegic symptoms.

**Chloral-poisoning.** In profound unconsciousness from chloral the subject is in a peaceful and undis-

<sup>1</sup> Read at the meeting of the Colorado State Medical Society, held at Denver, June 20, 21, 22, 1893.

turbed slumber; not a voluntary muscle moves, and all is calm. Breathing is rather slow and shallow, the pulse is soft, weak, and infrequent, and the temperature is usually slightly subnormal. There is complete absence of all local symptoms.

*Opium-poisoning.* The onset of the symptoms, if this is known, the equal and contracted pupils, the slow respiration, the normal temperature, and the absence of all hemiplegic symptoms, would point to opium-poisoning. If the symptoms began suddenly with a general or a partial convulsion, chloral, opium, and alcohol poisoning could be excluded.

*Alcoholic unconsciousness.* An alcoholic odor of the breath, a coma from which the patient may be temporarily aroused by loudly calling his name, equal pupils, nearly normal temperature, and the absence of unequal temperature on the two sides of the body, point to alcoholic poisoning. Violent struggling, when it occurs, strongly indicates alcoholism. There are no localizing brain-symptoms.

*Uremic coma.* Albumin and tube-casts in the urine suggest uremia, but albumin is frequently found in considerable quantity in the urine in cases of cerebral hemorrhage, especially if attended with convulsions, but tube-casts are usually, if not always absent, except when kidney-disease has preceded the hemorrhage. It must be borne in mind that renal disease, especially the senile form (granular disease of the kidney), occurs in about one-third of the cases of cerebral hemorrhage. The peculiar physiognomy of renal disease, with local dropsy, equal pupils, less profound coma, and usually nearly normal temperature (according to Gowers it is always subnormal, except in cases in which local inflammation exists), the presence of the odor of urine in the breath, and the absence of hemiplegic symptoms occurring in a young subject, are usually sufficient to diagnose uremic coma. Gowers states: "Rigidity of limbs or local muscular twitching during the coma is, if constant in seat, in favor of cerebral mischief; if variable in position it is in favor of uremia."

*Coma of epilepsy.* If the history of the patient is known and the onset of the attack has been witnessed, no difficulty will occur in the differential diagnosis. If the patient is first seen in post-epileptic coma, without any knowledge of his previous history, the absence of hemiplegic symptoms and the short duration of the coma would serve to distinguish the case from one of cerebral hemorrhage, except in the status epilepticus (a state rarely, if ever, reached without the history of the patient being known), when in the absence of a history of the case it would be almost impossible to exclude cerebral hemorrhage in which no hemiplegic symptoms are present. Fortunately for the diag-

nostician, in nearly all cases of cerebral hemorrhage attended by convulsions following each other in rapid succession, unilateral symptoms exist, but multiple thrombi and emboli may give rise to a condition resembling the status epilepticus without a single unilateral symptom.

*Hysterical coma.* I have yet to meet with my first case of hysterical coma in which difficulty has been found in excluding cerebral hemorrhage. In the cases that I have seen, the absence of all positive symptoms of organic disease and the presence of hysterical stigmata have rendered the diagnosis easy. The face is rarely, if ever, paralyzed in hysteria. The danger of mistaking cerebral hemorrhage for hysteria is much greater, and in some cases can only be avoided by a careful search for symptoms of organic origin.

*Apoplectic attacks of cerebral congestion.* In this condition the symptoms are general, with less profound unconsciousness than is found in cerebral hemorrhage. There are no local or hemiplegic symptoms. There is usually a history of previous similar attacks which have passed off without leaving any weakness of muscles. Gowers is inclined to the opinion that in first attacks of this character a positive diagnosis cannot be made.

*Apoplectic attacks in paralysis of the insane.* The previous history of the patient is usually sufficient to put the physician on his guard. The seizure is ushered in suddenly with convulsions, local in seat, clonic and tonic in character; the head is drawn to one side; the muscles of the eyes and face may keep up a constant twitching for hours; unconsciousness is profound; the face is dark; respiration is shallow and rapid; the pulse is quick and weak; the temperature is elevated; a profuse perspiration covers the body, and the whole aspect of the patient points to speedy dissolution.

The seizure lasts for a few hours or a day, and is followed by a sleep from which the patient slowly wakes and gradually recovers consciousness. A day or two later, however, the patient is apparently as well as he was before the attack, except that mental deterioration becomes more rapid, with a tendency to the formation of bed-sores and the development of other trophic disturbance. If one were called to see a patient in a first attack of this character without a history to guide him, a diagnosis from cerebral hemorrhage would be impossible. The same character of attacks occurs as a manifestation of cerebral pachymeningitis, and it is probable that these seizures in paralysis of the insane are due to hematoma of the dura, and the immediate cause is hemorrhage.

*Simple apoplexy.* In persons advanced in life a condition sometimes occurs with a train of symptoms that perfectly resembles that of cerebral hemor-

rhage, but at the autopsy no trace of hemorrhage or other gross cerebral lesion can be found. Such attacks are truly "mysterious" in their nature, and it frequently happens that they cannot be distinguished from cerebral hemorrhage.

**Embolism.** The younger the patient, with the presence of endocardial disease or syphilis, the greater the chances are in favor of embolism against hemorrhage, except in cases in which the apoplectic symptoms have been very severe, coma profound and long in duration. The parturient state favors embolism. The less the primary disturbance of temperature, provided the paralysis is extensive, the less the chances are in favor of hemorrhage.

**Thrombosis.** The differentiation of thrombotic softening from cerebral hemorrhage is probably one of the most difficult diagnoses that the physician is called upon to make. Gowers states that "Some writers contend that we can be sure of our diagnosis in only one-third of the cases." He does not agree with this broad statement, and believes that by a careful analysis and comparison of the symptoms an accurate diagnosis can much more frequently be reached than might be inferred from the writings of some physicians.

An accurate diagnosis is of considerable importance, because the treatment of the two conditions is entirely different. I will give the most important diagnostic points of each:

#### THROMBOTIC SOFTENING.

1. Prodromata frequent.
2. Great degeneration of the arteries of the limbs.
3. Pulse soft and often very compressible.
4. Heart feeble, dilated, and irregular.
5. Coma less marked in depth and duration.
6. Following grief and other depressing influences.
7. Local convulsions more frequent.
8. Slight initial temperature-disturbance.
9. Slight variation of the temperature within a few hours.
10. Secondary inflammatory symptoms frequent and well-marked.

#### CEREBRAL HEMORRHAGE.

1. Prodromata infrequent.
2. Turgid face and strongly beating arteries of the neck.
3. High arterial tension, regardless of the size of the pulse.
4. Heart hypertrophied and beating strongly.
5. Coma more intense and longer in duration.
6. More likely to be induced by mental excitement.
7. General convulsions more frequent.
8. Often great initial temperature-disturbance.
9. Often a considerable rise of temperature from twelve to twenty-four hours after the attack.
10. Secondary inflammatory symptoms less in frequency and in degree.

The foregoing is only an attempt to arrange the chief diagnostic points of thrombotic softening and cerebral hemorrhage side by side, but it must be evident to everyone that any one of the symptoms may be so modified by conditions and circumstances as to render it entirely valueless, *e. g.*, sudden fall of temperature, succeeded a few hours later by a rise of several degrees, indicates cerebral hemorrhage,

but in occlusion of the basilar artery the temperature may rise four, six, or even eight or more degrees, a few hours subsequently to the occurrence of the apoplectic symptoms.

#### TREATMENT OF CEREBRAL HEMORRHAGE.

I must reiterate what I have said on former occasions in connection with the treatment of a patient while in the apoplectic state from cerebral hemorrhage, that most of such patients would do better without medicine than they do when medicine is simply administered with the hope of doing some good, but the administration of which is not governed by any logical or rational principle.

If we bear in mind that in hemorrhage into the cerebral substance, not traumatic in character, the immediate cause of the hemorrhage is the bursting of a miliary aneurism, we shall appreciate how futile must be our efforts to arrest such a hemorrhage by the administration of medicine. Immediately after the occurrence of the event the indications are to allow the effused blood to coagulate, to promote the flow of the venous blood from the head, to quiet the heart's action, to allay the restlessness of the patient, when such exists, and to prevent an undue amount of blood being carried to the head. We can render the best service in aiding the coagulation of the effused blood by keeping the patient absolutely quiet. The flow of the venous blood from the head is promoted by slightly elevating the head and shoulders, and not allowing the head to be bent forward and thus compressing the veins of the neck. The heart's action is best quieted by the careful administration of small and frequently repeated doses of aconite, when there are no contra-indications to the use of this drug. Restlessness, when considerable, is most effectually relieved by a hypodermatic administration of one-fourth of a grain of morphin; when it is slight, sodium bromid is effectual. Various means are at our command to lessen the flow of blood to the head; sometimes one or two, sometimes all should be employed. Brisk purgation should almost always be resorted to. If the stomach is not irritable, one drop of croton oil in ten drops of sweet oil should be placed on the tongue every hour until the bowels are opened freely. When the stomach is irritable ten grains of calomel should replace the croton oil. Whether calomel or croton oil is employed, an enema, consisting of one ounce of salts, a half-ounce glycerin, and four ounces of water, should be thrown up the large bowel as soon as possible after the occurrence of the hemorrhage. Mustard plasters applied to the back of the neck, the front of the chest, and on the calves of the legs, aid in lessening the quantity of blood carried to the head. Blood-letting is sometimes indicated, but cases necessitating the with-



drawal of blood by opening a vein are probably rare. In regard to the administration of ergot in the cases of cerebral hemorrhage under discussion, I do not believe that it does a particle of good, and there is a possibility of its doing harm. The practice of applying cold to the head, especially ice, in cases of non-traumatic, intra-cerebral hemorrhage, is, I believe, reprehensible. It seems rational to suppose that it may increase the engorgement of the intra-cerebral vessels. When the face is turgid, the head warm, and the carotids throbbing, ice-cloths or iced poultices may reduce the heat of the head and promote the coagulation of the effused blood.

It will be seen that the only routine treatment recommended for intra-cerebral hemorrhage is brisk purgation immediately after the occurrence of the accident, to which may be added the application of mustard plasters to various portions of the body. In the subsequent treatment, during the acute stage indications must be met as they arise. In the chronic stage electricity and strychnin must be used with judgment and great caution. The routine employment of these two agents to overcome the paralysis does much harm in causing irremovable contractures of the arm and leg of the affected side. In this stage strychnin should not be employed when contractures are present, or when the deep reflexes are greatly exaggerated. We must remember that no hard and fast rules can be laid down in regard to the use of strychnin. I have seen cases in the acute stage in which this drug, in combination with aromatic spirit of ammonia, has done good service. When electricity is applied, and, as a rule, it should not be before the end of the fourth or sixth week, the extensor muscles only should be stimulated, and during the application the extremities should be held in their normal positions. Massage, systematic exercise, Swedish movements, and time, do most to overcome the residual paralysis of intra-cerebral hemorrhage.

**CHOREA.**—I wish to limit my remarks to the so-called acute chorea of Sydenham, as distinguished from the chronic chorea of which much has been written of late, especially of the hereditary form, known as Huntingdon's chorea. It is useless, in an article of this kind, to take up time with the diagnosis of chorea, as but little difficulty is encountered in differentiating it from other forms of nervous troubles.

In two papers written a few years ago, in which I considered at some length the influence of the climate of Colorado in relation to mental and nervous diseases, I expressed the opinion that chorea is no more frequent, is no longer in duration, and is just as amenable to treatment in Colorado, especially at altitudes varying from five to six thousand feet above sea-level, as I had found it in Philadel-

phia. In a third paper, entitled "The Influences of Climate, especially the Climate of Colorado, on Chorea," I was forced to the same conclusion. After a more extended experience with the disease in Colorado, I still find no reason to change the opinion expressed in the papers just referred to. I see so many cases of chorea that have been under treatment from several weeks to three or six months, which on being placed on a certain course of treatment, yield in two, or, at most, in three weeks, that I believe it may be pardonable in me to give in detail the plan of treatment that I almost invariably follow in the management of chorea.

For a number of years I have refused to assume charge of a case of this disease if the parents and friends will not consent to follow my instructions. In the very mildest cases, in which there is only an occasional grimace of the face, or an infrequent twitch of the muscles of the hand or foot, I allow the patient to sit up part of the day, and spend the remainder of the waking hours on a lounge. No violent or exciting exercise, such as romping, running, etc., is allowed. The patient is placed on a nutritious, digestible, but non-stimulating diet. The stomach and bowels are kept in as good a condition as possible. The patient, to begin with, receives as many grains of antipyrin at bed-time as he is years old, and the dose is increased one grain each night until all twitching stops. At the beginning of the treatment of these mild cases I commence with one drop of Fowler's solution after each meal, and increase the dose one drop each day until the point of tolerance is reached; then the arsenic is discontinued for two or three days, or until all unpleasant effects of its administration have passed away, when the drug is again resumed at the dose reached when it was stopped. The dose is again increased one drop each day until tolerance is reached, when it is discontinued, and resumed after two or three days as before. As soon as the twitching ceases, the antipyrin at bed-time is discontinued, and the patient is given syrup of the iodid of iron after each meal, in from three to ten-drop doses, depending upon the age of the patient. The arsenic and iron are continued for two or three weeks after all symptoms of the disease have disappeared and the patient has regained considerable flesh.

In all except the mildest cases, to which reference has just been made, absolute rest in bed, day and night, is insisted upon from the first. If I had to rely upon one method of treatment in the management of chorea, to the exclusion of all others, I should unhesitatingly choose absolute rest in bed. When the little patient is placed in bed to begin its treatment (we will suppose it to be a child of a few years, or not more than fifteen years of age), I am in the habit of ordering as many grains of antipyrin,



three times daily, after taking food, as the child is years old, and increase the dose one grain each day until all violent movements stop, when I begin with one drop of Fowler's solution after each meal, well diluted in water, and increase the dose one drop each day, in the manner described. About the second or third day after the arsenical treatment has been added, the antipyrin is given only once each twenty-four hours, and the time for its administration is usually about 8 or 9 o'clock in the evening, thus securing a comfortable night for the little patient. After all but the most occasional twitching has stopped, the antipyrin is discontinued, and syrup of the iodid of iron is given in connection with arsenic. It seems a little heroic to give a child of seven years of age from ten to fifteen grains of antipyrin three times daily, yet I have given a child of eight years twenty grains of antipyrin three times daily, without the slightest apparent depression or untoward effect. Certain precautions, however, are necessary. In the first place, if there is any rise of temperature, perspiration will be free, and depression will result. I have learned to avoid antipyrin in cases in which there is much rise of temperature. In such, chloral hydrate takes the place of antipyrin. I have never carried the dose of the former to nearly that of the latter. When there is cardiac weakness, antipyrin and chloral should be given with great care, if at all. When such a complication exists, phenacetin, with a little cannabis indica, seems to quiet the patient. Valvular disease of the heart alone does not seem to contra-indicate the employment of antipyrin, but cardiac dilatation does.

Whilst antipyrin is being given the patient must be kept at rest in bed. I have seen considerable depression follow a large dose of antipyrin when the little patient has been allowed to run around. During the administration of large doses of antipyrin or chloral the patient should be seen at least daily, and the urine should be repeatedly examined.

The questions in regard to arsenic in chorea: How large doses may be given? How long should the drug be continued? Should it be kept at the point of tolerance for weeks without intermission, and what unpleasant effects are likely to follow its administration in large doses? are pertinent.

How large doses of Fowler's solution may be given? As a rule, children from seven to fifteen years of age will bear larger doses of arsenic than adults. So far I have never found it necessary to give very large doses to children under six years. In a number of instances I have given twenty drops of Fowler's solution three times daily to children from ten to fifteen years old, for a week or more at a time. In the majority of instances the point of tolerance is first reached when the dose has been gradually

increased to some six or seven drops thrice daily. After stopping the arsenic for two or three days, or until all unpleasant effects have passed away, and resuming its administration at six or seven drop doses, as the case may be, the next point of tolerance will be attained when the dose has reached ten or twelve drops thrice daily. In most instances all twitching will have stopped at this time. If such be the case, the medicine is resumed after two or three days, at this dose, but now it should not be increased. It should be given at the dose tolerated when the twitching has stopped, for a week or ten days, then discontinued for two or three days, and resumed again at the full dose; the dose is now lessened one drop each day until four-drop or five-drop doses are reached; stopped again for two or three days, and again resumed at five-drop doses. Arsenic, as a rule, should not be continuously given in full doses for more than eight or ten days at a time. By observing this precaution I have been fortunate enough to avoid the ill-effects that some physicians have reported from the continuous use of full doses of arsenic.

How long should the administration of arsenic be continued after all twitching has stopped? As a rule, it should be continued for a month or more after all choreic symptoms have ceased, but not in full doses of toleration for more than a week or ten days, when it should be stopped for a few days; then the dose should be gradually reduced, as recommended.

The next question: Should the large tolerated doses be continued for weeks without intermission? has already been answered in the negative.

What unpleasant effects are likely to follow the administration of large doses of arsenic, even when the point of tolerance has been established by gradually increasing the dose from day to day? Seguin states that he has never seen any serious effects follow therapeutic doses of arsenic, although he gives some children as many as twenty-five drops of Fowler's solution thrice daily. Whether he takes the precaution not to use the drug continuously for more than a week or ten days at a time I do not know. So far, I have not seen any cases of neuritis following therapeutic doses of arsenic. Dr. Shattuck, of Boston, reports two cases of multiple neuritis following large doses of arsenic given for the relief of chorea. Dr. McGarvey, of San Luis, Colorado, informed me by letter a few days ago that he recently had two children paralyzed in the legs after taking large doses of arsenic for chorea. These were evidently cases of multiple neuritis. Neither Shattuck nor McGarvey states how long his patients had been taking arsenic without an intermission in the administration of the drug. Several other physicians have reported cases of

neuritis following the administration of arsenic for the relief of chorea.

In conclusion I will give brief reports of a few cases of chorea treated by antipyrin and arsenic in large doses.

CASE I.—Rose K., fourteen years old, of Austria, has been troubled with violent choreic movements (bilateral) for six months. She has been under treatment a portion of the time. The jerking of the limbs is so violent that it is difficult to keep her in bed. She is placed on fourteen grains of antipyrin three times daily, increased one grain each day. In four days, or by the time that eighteen grains of antipyrin are being given thrice daily, all violent muscular twitching is stopped. She is now given one drop of Fowler's solution thrice daily, and the dose is increased one drop each day, and the antipyrin is reduced to one dose of eighteen grains daily. In the meantime absolute rest in bed is insisted upon. At the end of the second week the choreic movements have nearly ceased, and by the end of the fourth week she is discharged, cured.

CASE II.—Helma B., thirteen years of age, has been suffering with violent choreic movements of the left side for three months. During this time she has been under treatment, but has been allowed to be up and walk around all day long. When she entered the hospital the twitching was violent. She is placed upon large and increasing doses of antipyrin and kept at rest in bed. In a week's time all violent movements have ceased. At the end of eighteen days she is now practically cured, under the antipyrin and arsenic treatment.

CASE III.—Charles R., fourteen years old, was admitted into the nervous ward of the County Hospital about two weeks ago. There was violent jerking of the muscles of all the limbs, and of the face. He had to be strapped in bed, as the irregular muscular action made it impossible for him, unassisted, to remain in bed. He states that he had been in this condition for six months. Articulation and deglutition are difficult. He is placed upon the same treatment given Cases I and II, with equally good results.

#### **PRACTICAL REMOVAL OF HAIRS, MOLES, ETC., BY ELECTROLYSIS.**

BY S. SORENSON, M.D.,  
OF RACINE, WIS.

THE theory of the removal of superfluous hair by means of the galvanic current is comparatively simple; it is to insert the needle attached to the negative pole of the battery into the hair-follicle, apply the current, and dissolve the tissues, when the thing will be done. However easy this may seem, when the physician tries to make a success of it in his everyday practice he finds it by no means so simple.

I shall try to give my views of how to make elec-

trolysis a practical success, and will not speak so much from theoretic grounds as from practical, almost daily, experience during a period of over two years.

I have used a McIntosh cabinet, and also a portable battery of the same manufacture. For some months past I have been using a ten-cell Flemming battery, and have found this very satisfactory. The dry chlorid of silver battery would no doubt prove very serviceable as a portable battery, but it has the disadvantage of being difficult to repair, so that should it get out of order when one is not near a place where it could easily be repaired, the inconvenience might be very serious.

I have used steel and platinum needles, and prefer the latter. For some reason the platinum does not seem to irritate the tissues so much as the steel; being also more pliable, it enables the operator to curve it as he wishes, and thereby more easily insert it into individual hair-follicles, which often curve so that they would be difficult to follow with a straight needle, this curving of the hairs being especially marked in certain parts of the face.

The holder I use at present is also manufactured by Flemming, and consists of an end-piece, cone-shaped, with a longitudinal slit to hold the needle; this part is turned into the end of the holder, which covers the slit and holds the needle. I consider this holder far superior to that class in which the needle is held by a set-screw, this screw obscuring the vision when the operator attempts to insert the needle. Some holders are made with an interrupter in the shape of a button which must be pressed by the finger of the operator when the current is to be stopped. This does not seem to me to be a good arrangement, for the time when the current is to be discontinued is the time during which the needle is being inserted into the follicle; when that is to be done the operator must have as much freedom of movement as possible, as no considerable force should be used, but the needle should insinuate itself along the opening until the bottom of the follicle is reached, which will at once be noticed by the experienced operator. If force be applied in inserting the needle, this will probably be driven in too far, or passed through the side of the follicle, with a poor result in either case.

Having, then, a battery of the proper kind, cords, a finger-bowl for water, needle and holder, a pair of small tweezers, and a comfortable arm-chair with some appliance upon which the operator can rest his elbow, one has the essentials for the work. The chair should be placed where a good light will fall on the patient's face, a towel placed in the patient's lap, and upon it a finger-bowl about two-thirds full of water, in which is a sponge-electrode connected with the positive pole of the battery. The cord

attached to the negative pole is fastened to the needle-holder.

Let us suppose that the patient has not been under treatment before, and wishes hairs of medium size removed from the chin. The operator will turn on two cells, seat himself with his back to the light, and sufficiently close to the patient so that he will not have to exert himself in reaching; he will then insert the needle to the bottom of the follicle, then tell the patient to dip one finger into the bowl and keep it there until asked to remove it. In inserting the needle the holder should be held with the same gentle firmness that a pen is held, the third and fourth fingers resting lightly on the skin near the hair to be removed, so as to gently steady the hand. The operator will also find it a great help if he will rest his elbow on the arm of the chair, or some other support.

The first indication of results is a white froth, which makes its appearance at the mouth of the follicle, around the needle. Depending on the strength of the hair and the force of the current, the operator will judge whether the hair is loose. When he wishes to attempt its removal with the tweezers he will ask the patient to remove her finger from the water, and will then seize the hair with the tweezers and make gentle traction; if the hair makes any appreciable resistance the needle must be reinserted and the current again applied. When the hair is entirely loosened by the current a good result may be looked for. Should the hair offer resistance, the physician may insert the needle into the follicle after its removal and continue the current, but, as a rule, I have found it more difficult to insert the needle after the removal of the hair than when it is in situ.

After one has had experience he calculates almost unconsciously the length of time the current is required. When this faculty is acquired, cognizance is also taken of the strength of current and the particular person upon whom one is operating. I have also found that the patient can leave her fingers in the water constantly, and need not remove them unless I experience difficulty in finding the opening of the follicle. These things must all be taken advantage of, for in the long run, if properly utilized, they save much time, and thus shorten an operation which must always prove trying to both operator and patient.

No hard and fast rules can be laid down for doing this work, and each individual operator will be called upon to exercise his judgment in the case of each one upon whom he operates, and much of the time upon the individual hairs.

After what has been said in a general way of the operation, I will attempt to notice some of the features that should be avoided or should receive

special attention. In the first place, the part operated upon should be surgically clean. Next the needle should not be inserted more deeply than the bottom of the follicle. Experience will indicate when the needle is at that point by a slight sense of resistance. Should the needle be inserted too far, considerable tissue may be destroyed, and still the hair will not be loose. Another thing to avoid is passing the needle through the side of the follicle, something which experience also teaches one to recognize by the touch. If this be done and the current applied, a white spot will begin to spread around the needle; the result with regard to the hair will be the same as in the former case, and in both a vesicle may form, with some exudation of serum, and with the danger of subsequent pustulation, and formation of a pitted scar.

Another danger is that of operating during a given time on hairs too close to each other. Here again the operator must fall back on his judgment, and take into consideration the size of the hair and the amount of electricity it takes to destroy it; also the regenerating power of the patient's tissues, which will be learned by observation. This rule may be laid down, that, until the operator becomes acquainted with his case, he must be sure not to take the hairs out when they are too close together. This is a matter of a great deal of importance, for frequently patients whose time and money are limited will urge the doctor to take out hairs that are too close together to be operated upon with good results in one day, or even on two successive days.

Again, the temporary inflammation which always sets in does not fully show itself until after several hours, so that a patient may leave the office with a face that shows comparatively little trace of the operation, but will return next morning with that part of her face in a very sorry-looking condition. I repeat that the importance of what I have just said cannot be overestimated, for upon proper attention to this matter may depend the success or failure of the operation, at least so far as the question whether or not the patient will have a smooth face after the hairs have been removed is concerned.

How long shall a patient sit at one time? This will depend upon how sensitive she is to the current. To illustrate: I have encountered only two cases in which patients complained of being unable to undergo the operation. One of these had been in the chair for several hours, and was obliged to discontinue treatment for that day. The other complained at the beginning, but was able to endure having all her superfluous hair and a couple of moles removed at the one sitting. As regards the duration of the operation, the amount of time at the disposal of the patient, and the extent of surface covered by the growth, are factors.



As a rule, all things being convenient, the best plan would be for her to take treatment for an hour and a half at a time, two or three times a week. When necessary, however, patients will sit for hours at a time without complaint. I have operated as long as seven consecutive hours in one case, but three hours is about as long as any patient cares to sit continuously, and this length of time will also try the operator.

The number of hairs that can be removed in an hour must necessarily vary, depending on much the same conditions that have been mentioned; but I believe a fair estimate will be thirty per hour, all classes of patients considered.

Patients are of all kinds, from the girl of sixteen or seventeen, who has noticed a few hairs on her face—usually on the upper lip at the corners of the mouth—which she knows or imagines that people notice, and which she supposes give her a masculine appearance. Next comes the older woman, who, to a practised eye, bears the unmistakable evidence of having a tendency to a hairy growth on the face; this she is making desperate efforts to conceal from the public by the use of tweezers or depilatories. Then there is the older woman still, who has passed fifty, and even sixty years of age, who, perhaps, even used the razor. Young or old, life is made unhappy by the disfigurement, and in some cases it means a life of misery if it is not permanently removed. A number of men also want hair removed for various reasons, but they are few compared with the women, and, in my opinion, the physician need waste no sympathy on them. That the disfigurement is very prevalent one can easily convince himself by taking special notice of the faces seen on any fashionable thoroughfare, and such cases deserve the consideration of the intelligent physician.

Can these hairs be destroyed by means of the electric needle, and leave no mark on the face? To the first part of the question I believe my experience will entitle me to answer in all cases, yes. To the second part, no. I believe that every time a hair is destroyed a scar is left, for by this process some of the tissue surrounding the hair is destroyed, and, as a consequence, we have cicatricial tissue formed. But I will say again that by proper care on the part of the operator, the marks left will in the majority of cases be so small that no one who does not know what he is looking for will be able to detect them; so that practically the hairs can be removed without leaving scars. In cases in which the hair is coarse and thick there is, of course, greater liability to scarring, and it seems to me that a great deal also depends on the healing powers of the tissues of different individuals. A certain, or rather uncertain, number of hairs will return, though in what proportion I am unable to

say. The smallness of the number of returns, I am led to believe, will be in direct ratio to the skill of the operator. The trying cases often take such a long time to finish—for reasons that will be plain to those who have read this—that it is difficult to follow them up. I have in mind four cases, three of which were very severe, the fourth one the worst I ever operated upon. Two of these are entirely cured, several months having elapsed since the last operation, with no return of the trouble. The third case, a very severe one, is also practically rid of the trouble, while the fourth is still under treatment, with every indication that her face will soon be in good condition. Perhaps the best criterion as to whether or not the work is a success is the fact that these cases persist in the treatment for months and years. The last case I mentioned has been under treatment, off and on, for nearly two years. Some idea of the amount of work a severe case requires may be gained from the fact that since the 25th of April, 1892 (now February 1, 1893), I have spent *eighty-six* hours operating on the face of the last-mentioned patient.

Another use to which I have put electricity in the form of the galvanic current is the removal of moles and enlarged cutaneous bloodvessels, such as are frequently seen on and around the alæ of the nose and also on the body of that organ. For convenience, I divide moles into two classes, not that the appliances for removing them are different, but that the *modus operandi* differs somewhat in each. The apparatus for removing moles is the same as that used for the removal of hair, with the exception of the tweezers.

The first class is the very common disfigurement called liver-spots, which are really pigmentary moles, or perhaps, exaggerated freckles. They are little, if at all, elevated above the surrounding surface. The method of procedure in the case of these is as follows: The patient and operator take the same positions as in the removal of superfluous hairs, the parts to be operated upon having been thoroughly cleansed. The operator now inserts the needle at the edge of the mole, just beneath the epidermis, applies the current, which should be weak, and gradually passes the needle through the growth. As the electrolysis goes on it will be observed that a loosening of the pigment takes place, and it mixes with the froth around the needle. The needle must now be worked over the entire area of the mole, taking care to go no more than deeply enough to loosen the pigment. After a few seconds the burning sensation that accompanies the insertion of the needle ceases, in consequence of the local anesthetic effect following the application for a limited time of a comparatively weak current. The whole operation can be completed with only one puncture of the epidermis,

although in small moles that is a matter of little consequence. The pigment and dissolved tissue are now left to dry into a crust, which comes off in a few days, leaving a bluish-red spot, as always happens when a bit of the epidermis has been scraped off, and which later becomes the color of the surrounding skin.

The next class of moles includes those that are elevated above the surrounding surface, and which frequently contain a number of hairs. As a rule, the first thing to do is to remove the hairs, which, if few, can be done at the same sitting the mole is operated upon, and in the manner described in the first part of this paper. It is very essential that the surgeon, when operating on moles raised above the surface, should constantly bear in mind the object which he sets out to accomplish, namely, to bring the elevated spot down to a level with the surrounding surface. Great care must be exercised not to bring it below, for in that event a mischief is done which no method I know of can cure. The larger the mole the greater the liability to pitting if due precautions be omitted. In this class of moles the needle is inserted at the base of the growth and gradually passed through it, and may be passed out at the opposite side. This is repeated until the whole base has thus been treated, the object being to cut off the circulation by electrolyzing the blood-vessels at the base of the growth.

The first sign produced in the mole will be a gradual whitening of that part external to the needle, which finally reaches an appearance of complete anemia. The electrolysis must continue until the circulation is entirely cut off. Inside of twenty-four hours the whiteness will have disappeared and be replaced by a black color. There soon follows a dried, hard crust, the time depending upon the size of the mole, which falls off in a few days, leaving a discoloration that gradually disappears.

As a rule, it is not advisable to attempt to remove a mole at one sitting, unless it be quite small, for fear of leaving a scar. If moles be large there may be some oozing of serum during the operation, but that is a matter of little consequence, and a little dusting powder may be applied after the operation.

When it is decided that a mole is to be removed, the operator, before he begins, must fix in his mind how deeply he should penetrate, for there is likely to be some swelling around the margin, and he will have only his memory to rely upon to guide him. For that reason it is advisable not to attempt to remove the whole of the mole at one sitting, but to destroy a given amount. Then, after the crust has come away, the edges, or any part, may be trimmed down very easily, without any danger of going too far in, as might be the case did one try to remove a comparatively large growth at a single sitting.

Occasionally small pedunculated moles are found on the eyelids, which may be removed as the others are, and, if the operation be properly done, without any inconvenience to the patient.

I have occasionally been called upon to destroy enlarged bloodvessels in and around the region of the nose. To do this the needle is inserted into the vessels at their largest part, and the current turned on. Almost immediately a white substance will be seen to make its way along the vessels, distinctly outlining them. The vessel-walls must be destroyed throughout the whole extent, the needle being inserted at intervals along their course. The operator should experience little difficulty in doing this, as he can see his work. The greatest trouble he will have will be the extreme sensitiveness of the part, which frequently manifests itself in an uncontrollable desire to sneeze, though frequently the pain is severe in operating in the region of the nose, as also in removing hairs from the upper lip.

I applied cocain in one case when operating on the mucous membrane of the anterior nares, but it did not seem to deaden the sensation. I think, however, that cocain ought to be successful in these cases, and intend to try it again when the occasion arises.

In operating upon enlarged cutaneous vessels, it follows, as a matter of course, that the operation must be thorough; in other words, the current must be applied until the vessel-wall is destroyed.

I have also used electrolysis in two severe cases of ingrowing eyelashes—trichiasis-distichiasis—both upper lids being involved in one case, and one lid in the other. I cannot report on the ultimate effect of the operation, for I lost sight of both cases before sufficient time had elapsed to show definite results. I can say that the removal of the hairs may be accomplished more quickly than one would at first think. In one of these cases I removed all of the hairs from one lid at one sitting, with the result that when the patient returned a week later to have the hair removed from the upper lid of the other eye, he declared the eye that had received the first attention felt better, and he could see better with it than he had been able to do for a long time.

I used cocain, operated on the worse eye first, which, in consequence of the irritating hairs, was nearly blind. The patient was seventy years of age, and far from strong. I did not see him again after removing the hairs from the other eye.

In closing I will recapitulate as to certain things which must always be borne in mind in performing any of the operations I have mentioned:

1. Do not begin with too strong a current.
2. Apply the current for a sufficient length of time.

3. Always apply the negative pole to the part it is desired to destroy.

4. Do not have the circuit closed when you insert the needle until you have learned to know your patient *electrically*, if such use of the word may be permissible.

5. Always test the strength of your current before beginning. To do this I have found a convenient way is to touch the two poles to my tongue, having the points about an inch apart.

### THE SURGICAL TREATMENT OF CHRONIC TYMPANIC VERTIGO, OFTEN MISCALLED MÉNIÈRE'S DISEASE.<sup>1</sup>

BY CHARLES H. BURNETT, M.D.,  
AURAL SURGEON PRESBYTERIAN HOSPITAL, ETC., PHILADELPHIA.

CHRONIC tympanic vertigo, the most frequent form of aural vertigo, is one of the results of chronic catarrhal otitis media. It is always found in connection with tinnitus aurium and deafness, still commoner results of chronic aural catarrh. Unfortunately, chronic tympanic vertigo usually receives the very unjust and inaccurate designation of Ménière's disease.

The latter term, if it means anything—and it has but a very slender title to the wide acceptance it has met with in medical nomenclature—means a form of aural vertigo due to disease of the semi-circular canals. Disease of these canals, however, is very rare, and difficult to diagnosticate.

The name "Ménière's disease" is *inaccurate*, because it is indiscriminately applied to all forms of aural vertigo, regardless of the seat of the otic lesion, whereas Ménière attempted to prove the existence of a disease of the semi-circular canals as the only cause of aural vertigo, an entirely untenable hypothesis. The name is *unjust*, because Flourens in 1822, and Deleau in 1836, described aural vertigo more accurately than Ménière in 1861,<sup>2</sup> and Deleau came much nearer than any previous observer to the solution of the cause of most cases of aural vertigo in placing the origin *in lesions of the middle ear*.

Tympanic vertigo, due to lesions in the middle ear, is of frequent occurrence. It is often not recognized, especially by the general practitioner, as aural vertigo. It is not unusual for tympanic vertigo to be attributed to intestinal disturbance, or to "neurasthenia," instead of to an aural lesion. Hence, the diagnosis being erroneous at the outset, the treatment is wrong, and the patients do not recover.

True tympanic vertigo, due to a lesion in the

middle ear, chiefly from chronic catarrh of the tympanic cavity, is paroxysmal in character, and attended with tinnitus and deafness in the affected ear. It is caused by the inward pressure exerted upon the labyrinthine fluid by the retracted and ankylosed ossicles. The foot-plate of the stapes is thus unduly pressed into the oval window, and there held by the force named, paroxysmally and for longer or shorter periods.

I have long maintained the tympanic or mechanical origin of most cases of aural vertigo, in opposition to the asserted neuropathic, or labyrinthine cause.<sup>1</sup>

In chronic catarrh of the middle ear there must always be, sooner or later, a disturbed tension in the conductors of sound, whereby at times the membrana tympani and the three auditory bonelets are carried unduly inward, and exert a morbid pressure by means of the impacted stapes upon the fluid in the labyrinth. This irritation in the labyrinth being communicated to the motor filaments of the auditory nerve is reflected by them to the cerebellum, and disturbed equilibration is the result.

This morbid retraction of the auditory chain, and resultant cerebellar irritation, are not constant, but vary with the state of the general health and the condition of the catarrhal middle ear. Hence all true aural vertigo of tympano-mechanical origin is paroxysmal in form.

If the theory is correct that the vertigo in chronic catarrh of the middle ear is due to the retraction of the conductors of sound and mechanical pressure upon the labyrinthine fluid, then the surgical removal of such retraction and pressure ought to relieve tympanic vertigo.

No opportunity to test the truth of this theory offered itself until May, 1888. Then, being consulted by a former patient with chronic catarrh of the middle ear, for the relief of constant tinnitus, and oft-recurring attacks of *severe tympanic vertigo*, which had been superadded to her deafness in the left ear within the previous two years, and finding that the malleus had become adherent to the promontory, I resolved to do what, so far as I know, had never been done for the relief of aural vertigo of a mechanical or tympanic origin, viz.: to cut out the membrana tympani and the malleus, in order to liberate the impacted stapes.

This case and the entire success attending the operation have been fully detailed in other places.<sup>2</sup> I would like to state here that the entire relief from tinnitus and vertigo, which followed immediately upon the operation five years ago, has continued to

<sup>1</sup> Read by title and synopsis at the meeting of the American Otological Society, July 19, 1893.

<sup>2</sup> Gazette Médicale de Paris, September 21, 1861.

<sup>1</sup> "Aural Vertigo." Philadelphia Medical Times, June 3, 1882.

<sup>2</sup> The Polyclinic, August, 1888; The American Journal of the Medical Sciences, February, 1889, and the Transactions of the American Otological Society, 1890.



the present time. All the operations referred to in this paper were performed upon the etherized patient, the ear being illuminated by a six-volt electric lamp, held on the operator's forehead.

The operation of excision of the membrana tympani with the malleus was applied in four succeeding cases of chronic tympanic vertigo with entire relief in all of them.<sup>1</sup> However, as in all of the cases more or less inflammatory reaction followed this operation, I concluded that removal of the incus alone, or of the incus and stapes, the membrana tympani and the malleus being permitted to remain in position, would liberate the stapes and the compressed labyrinthine fluid, as well as, or perhaps better than, total excision of the membrana and the malleus, and probably would not be followed by inflammatory reaction. And the notes of the following cases will show that I was correct in my assumption.

The first case to which I would call attention was described in detail as Case V, in THE MEDICAL NEWS, of March 13, 1893, not as one in which tympanic vertigo was at all prominent, or in which the operation was performed chiefly for the relief of that symptom. The prominent symptoms were dullness of hearing and annoying tinnitus, and to relieve these the operation of removal of the incus and stapes was undertaken. But as there had been some slight vertiginous attacks, and as the operation was successful in relieving the deafness and tinnitus, and preventing the recurrence of further attacks of even slight tympanic vertigo, it may be regarded in this instance as at least a prophylactic of pronounced tympanic vertigo.

The next case was described as Case VI, in THE MEDICAL NEWS of March 13, 1893.

This is the only case in the series in which the stapes was removed entirely. The result was so good—in fact, so much better than in some in which the stapes was only liberated or only its crura were removed, that I am inclined to think that in any case of tympanic vertigo in which liberation or partial removal of the stapes does not give as much relief as is desired, *puncture of the foot plate* of the stapes, in order to relieve the labyrinthine tension, would be justifiable.

**CASE VIII. Removal of the left incus for aggravated chronic tympanic vertigo.**—Mrs. T. R. G., aged fifty-five, the wife of a physician, has had chronic catarrhal otitis media since childhood. The tinnitus has increased of late years, and she has been treated for years, by a prominent physician, for neurasthenia. Within a year or two marked tympanic vertigo has set in, and increased to *weekly* attacks, quite laying her up in bed when a paroxysm occurred. These attacks usually have come on in the house, sometimes in bed, but once lately the patient

was attacked while out driving. The attacks of vertigo were attended with increased tinnitus, nausea, and vomiting, without loss of consciousness, the face and forehead being bathed with cold sweat. There has never been any rational aural treatment in this case. The patient has been treated with purgatives and alteratives for "neurasthenia," and has grown steadily worse.

Examination of the left ear revealed a retracted membrana tympani, with signs of sclerosis of the drum-cavity. The incus and stapes were visible through the membrana. No catarrh of the nares or naso-pharynx. Tuning-fork heard *per ossa* in the affected ear. Loud words could be heard near the ear. The right ear is good, but said to be failing lately.

As the attacks of tympanic vertigo had now become so well marked, and so distressing, her husband had determined to seek relief for her by means of the removal of the force impacting the stapes in the oval window. Therefore, on June 7, 1893, the patient was etherized, and after excision of the posterior, superior quadrant of the membrana, the incus, though held tightly in place by synechiæ, was quickly removed. The stapes was found firmly and immovably fixed in the oval window, and could not be removed, its head being broken off in the endeavor.

There was no reaction in this case, and the patient went home, a hundred and fifty miles away, on the third day.

On June 25, three weeks after the operation, her husband wrote that "she has been getting on so well that we have some how failed to report to you of her general improvement. The first week after the operation she had several very *slight attacks* of vertigo, but they passed off very soon, and of late she has had no trouble whatever." She has been able to go about the house attending to her duties, without the fear even of the hindrance previously experienced from the attacks of tympanic vertigo. The tinnitus became much less, and the hearing improved a little. But the great end had been attained, viz: the relief from the sickening and incapacitating tympanic vertigo.

On August 8, 1893, her husband wrote that there had been some attacks of slight vertigo since his last letter, but nothing severe. Before the operation the patient had been bed-ridden by the severity and duration of the vertigo. September 10th. The patient remains free from vertigo.

**CASE IX. Removal of the incus only.**—Sister —, a nun, twenty-five years old, has for several years suffered from tinnitus, deafness, and tympanic vertigo, due to sclerotic otitis media of the left ear, following a chronic purulent otitis media, which latter ceased years ago. There was a perforation of the posterior inferior quadrant, with calcareous patches in the upper posterior and upper anterior quadrants of the membrana. The tuning fork was heard well *per ossa*, and isolated words were heard *close* to the ear.

June 28, 1893, the patient was etherized, and the perforation enlarged and extended into the upper posterior quadrant, exposing the incus lying high up in the attic. The incus was then removed.

<sup>1</sup> International Clinics, January, 1892.

The next day the hearing for isolated words in ordinary tone was two feet, and for whispered words from eight to ten inches. The patient was not seen again until July 20, 1893, when she reported that there was no more tinnitus or "swimming in the head." There had been no return of these symptoms by September 1, 1893. The result in this ear has been so good that a similar operation is contemplated for the relief of dulness of hearing and tinnitus in the other, the better ear.

CASE X. *Resection of the long processes of both incudes for the relief of deafness, tinnitus, and severe chronic tympanic vertigo.*—Mr. Charles C. T., aged thirty-one, of Baltimore, Md., has been affected with chronic catarrhal otitis media in the right ear for eight years, and in the left ear for four years. Within a year the tinnitus has become severe in both ears, and the hearing has failed in both, the left ear being a little better for hearing, however, than the right ear. In addition to these symptoms there had been superadded the tendency to attacks of tympanic vertigo, with temporary increase of tinnitus aurium in both ears at the time of the vertiginous paroxysms. So severe have the latter been as to require the patient to hold on to the nearest objects in the street to prevent him from falling. He has never vomited, however, in any of these attacks, but their severity and frequency have dispirited him, and prevented him from attending to his duties. For many months past the patient has been treated for an asserted catarrh of the nares, naso-pharynx, and throat, but the deafness, tinnitus, and vertigo have grown worse rather than better. Examination, June 18, 1893, revealed the membranæ tympanorum slightly retracted, the incudes and stapes visible through the membranes. The nares, naso-pharynx, and fauces were not affected.

July 21, 1893, the patient was etherized, and I endeavored to remove first the right, and then the left incus, after their exposure by exsection of the posterior, superior quadrants of the membranæ.

The right incus seemed firmly held in the attic, and when traction was made on the long process it quickly broke off. No further attempt to remove the body of the incus was made, as the object sought, viz.: severance of the retractive power of the incus from the stapes, had been attained. I met with the same experience on the left side.

The next day there was a slight reaction in both ears, the tinnitus was no better, and the hearing was perhaps a little duller in the *left*, the better ear. There was no vertigo.

The patient returned to his home now, and reported to me in the course of four days that he had had no vertigo, but he felt worse in his ears, and that he had had some fugitive pains in them, with a little bleeding from one.

August 11th. The patient reported "a slight improvement in hearing in the left ear, but none in the right." The tinnitus still continued, but there had been "an entire absence of vertigo." The left ear had pained him "quite a good deal, and felt uncomfortable for the past day or two."

August 13th. The patient's sister, a physician, reported to me that there had been an "evident

improvement in his hearing in the last ten days." Also a great improvement in his spirits.

September 3, 1893. The patient wrote that "the hearing in my left ear is much improved. I can hear conversation in ordinary tones about four feet, and if loud about ten feet. If the windows are open I can hear calls on the street. There is scarcely any roaring in the left ear, but in the right (the deafer ear), though diminished, there is quite a good deal. The hearing in the right ear seems to be about the same as before the operation." There has been no return of the attacks of tympanic vertigo. The perforations in the membranæ tympanorum persist.

It is noteworthy that in this case relief followed the severance of the retractive force by resection of only the long processes of the incudes; also, that most improvement in hearing and relief from the annoying tinnitus ensued in the better ear. This is due to the fact that greater mobility of the stapes has persisted in this ear than in the worse ear, and hence liberation of the freer stapes and the passive motion exercised upon it by sound-waves, have greatly improved the function of hearing in this ear. The result in this respect should encourage the surgeon to operate on both ears, or upon the better rather than upon the worse ear alone, when both are so profoundly affected as in this case. Most important is it to observe the *progressive improvement* in this case, as in some of the others. This must be due to the passive motion exerted upon the ankylosed stapes by sound-waves, which fall upon it more freely than before the operation.

From all the ten cases we may conclude:

1. That removal of the retractive force of the sound-conductors upon the stapes is the efficient means of relieving the tinnitus, deafness, and vertigo, due to the lesions of chronic catarrh of the middle ear.

2. That the removal of the retractive force upon the stapes can be accomplished efficiently and simply by removal of the incus alone, and even by resection of its long process.

3. That the improvement in these cases is due to the liberation of the stapes from the retractive power of the tensor tympani muscle, and the consequent unimpeded action of the stapedius muscle, which, relieved of the antagonism of the tensor tympani, tends all the more to draw the stapes from the oval window, thus aiding in the isolation and improved mobility of the bonelet, as well as in removing its undue pressure inward upon the labyrinthine fluid.

4. It would seem wiser, therefore, in most cases of chronic catarrhal deafness, tinnitus, and vertigo, not to sever the stapedius tendon and remove the stapes, but to be content with removal of the incus only.

5. The progressive improvement in hearing noted

in many instances, especially in Case X, must be due to the passive motion exerted upon the ankylosed stapes by sound-waves, which are enabled to reach this bonelet more freely after the removal of the incus.

**PARESTHESIA OF THE PHARYNX AND LARYNX  
AS A PREMONITORY SYMPTOM OF  
TUBERCULOSIS OF THE  
LUNGS.<sup>1</sup>**

BY JULIUS WOLFENSTEIN, M.D.,  
OF CLEVELAND, OHIO.

PARESTHESIA of the pharynx and larynx is an affection often encountered by the laryngologist, and the etiology which suggests itself to his mind is, primarily, hysteria and hypochondria, and secondarily the results of injury to the mucous membrane from the swallowing of some hard substance. That these are etiologic factors in a large percentage of the cases of paresthesia of the pharynx and larynx is established beyond doubt; in fact, most of the modern text-books mention no other cause.

To cite but a few instances: Bosworth, in his late work on the *Diseases of the Nose and Throat*, has a very unsatisfactory, brief article on this affection, and he believes that most cases of paresthesia can be traced to some local pathologic condition. This same view is also most strongly upheld by Lennox Browne in his well-known text-book.

It is true, Bosworth does mention that the affection occurs in anemia and pulmonary tuberculosis, and in individuals of nervous temperament, but in such a cursory manner that the reader perceives that he lays very little stress on the subject.

As another example, take Schrötter's *Vorlesungen über die Krankheiten des Kehlkopfes*, etc., published within a year. This author states that most cases of paresthesia of the larynx are due to injuries produced by swallowing some hard substance; hypochondria and hysteria come next, and anemia is casually mentioned among the causes. Without quoting any more authorities, except to say that Mackenzie, with his wide experience, merely mentions a nervous and traumatic etiology, which would simply be a reiteration of what has been said before, allow me to call attention to but one more text-book on this subject. Gottstein, in his *Krankheiten des Kehlkopfes*, which by the way is certainly the most excellent treatise on this subject extant to-day in any language, calls attention to the fact that paresthesia of the larynx is one of the frequent symptoms of the early stages of tuberculosis of the lungs.

The first one to call attention to this fact was, I

believe, Jurasz in his monograph on the subject of "Sensory Neuroses of the Pharynx and Larynx." This was published as early as 1881, but it seems that the subject has not received the attention which its importance demands.

In his monograph, Jurasz remarks that these cases of paresthesia are "relatively not rare complications of beginning tuberculosis of the lungs." As mentioned before, Gottstein's observations coincide with those of Jurasz, and as far as my personal experience goes, which I admit is not very extensive, I have seen at least half a dozen cases of paresthesia of the pharynx and larynx in the past three years, whose causation could be traced to no other source than probable beginning tuberculosis of the lungs. The history of several of the cases afterward positively proved the correctness of my supposition.

As regards the symptomatology of this affection I can be brief. Paresthesia of the pharynx and larynx manifests the same indefinite and varied subjective sensations that characterize this peculiar symptom as an accompaniment of so many nervous affections, such as tabes dorsalis, cerebro-spinal sclerosis, etc. The patients complain of pain, which they now locate in the region of the larynx, now in the tonsil, now in the tongue, now on one side and now on the other. The abnormal sensation is never constantly present in a definite locality. Again some patients complain of the most peculiar and unheard-of sensations of tickling, scratching, burning, pricking, numbness, dryness, etc. Schrötter mentions the case of a patient who said he had a sensation as though "a mouse had run through his throat." As is so universally the case in sensory neuroses of the body in general, the perverse sensations complained of are peculiar and preposterous in direct proportion to the morbid imagination of the patients. The only definite thing in the history of this class of cases is the indefinite character of the symptoms; that is, the uncertainty on the part of the patient of localizing and describing the perverse sensations and the oftentimes changing character of these sensations.

Besides these sensory neurotic symptoms, there are also present at times paroxysms of cough, in the vain attempts to remove the irritation felt by the patients. There are also present at times motor neurotic symptoms, like contractions of the laryngeal and pharyngeal muscles, which are very disagreeable to the patients.

Coming to the most important part of my paper, the differential diagnosis of the various kinds of paresthesia of the pharynx and larynx from the etiologic standpoint, I shall try to be brief and give you succinctly the most important symptoms that characterize this affection as an accompanying,

<sup>1</sup> Read in part before the Ohio State Medical Society, Put-in-Bay, Ohio, June 29, 1893.



and particularly as a premonitory, symptom of pulmonary tuberculosis.

In every case of paresthesia of the pharynx or larynx a most careful local examination must be made, to exclude any local pathologic condition as a cause for the paresthesia. It is hardly necessary to add that, particularly in nervous individuals, a naso-pharyngeal catarrh, a chronic pharyngitis or laryngitis, or even the tiniest of those almost universally-present granulations on the posterior wall of the pharynx, or hypertrophy of the lingual tonsil, may produce paresthesia. All local causes must therefore be first excluded.

The hysterical cases are generally easily excluded from the history, and from the fact that there is usually present in almost all of these cases the well-known globus hystericus.

The hypochondriac cases are more difficult of exclusion. They are generally found in otherwise healthy individuals who use their voices professionally, *e. g.*, teachers, singers, clergymen, etc. Another class of these hypochondriac patients are the syphilophobes who constantly imagine that syphilis is manifesting itself in their throats. I have under observation a very striking example of this kind. A patient visits me regularly several times a year, complaining of a peculiar train of symptoms—tickling, pricking, drawing, etc. Still I have never been able to find anything abnormal. The man is perfectly healthy, but he had a chancre several years ago. He is fearful that syphilis will “break out” in his throat, and he comes to me several times a year for consolation.

As regards the class of cases due to injury of the mucous membrane produced by swallowing some hard substance, when the patients complain of the sensation of a foreign body in various portions of the throat, the history of the cases will generally give us a clew as to the character of the paresthesia. The patient can generally state definitely when the peculiar symptoms were first noticed, and their beginning can then in most cases be traced to an injury produced by swallowing some substance which, by its irregularity or hardness, wounded the mucous membrane of the throat. This wound or injury, which may be so slight as to escape detection, on even the most careful examination, may give rise to the sensation of a foreign body in the throat. These painful or disagreeable sensations can, as a rule, be perfectly localized by the patient, and their locality does not vary. A most careful examination of the entire throat and naso-pharynx must be made, so as to be positive that there really is no foreign body present, and after this is done, appropriate measures should be used to remove as speedily as possible the inflammation and irritation following the injury. But there are cases of so-called

imaginary foreign bodies in the throat, in which the peculiar sensations complained of by the patient cannot be traced to any injury of the mucosa or to the presence of a foreign body. These cases generally occur in anemic individuals, particularly women. They are very refractory to treatment. I am inclined to believe that the majority may perhaps be included under that category of paresthesia of the throat which is premonitory of tuberculosis of the lungs.

Allow me to give in brief the history of only two cases of this nature. I believe this will best bring out the points in the differential diagnosis that I wish to make. In the first case the paresthesia was an accompanying symptom, in the second case it was a premonitory manifestation of pulmonary tuberculosis.

CASE I.—About three years ago a man of twenty-five years of age was sent to me for treatment. For the preceding few months he had noticed the following symptoms: A peculiar, indefinite sensation of pain and burning in the various regions of the throat, now in the palate, now far back in the pharynx, now on one side of the larynx, now on the other. He could not state definitely either the cause or the time of the beginning of these symptoms. He also coughed occasionally. There was a history of tuberculosis in the family. A careful examination of the nose, naso-pharynx, pharynx, and larynx revealed nothing abnormal outside of a slight redness of the true vocal bands; but as the man used his voice considerably, this was not surprising. An examination of the lungs revealed a moderate degree of apical catarrh on both sides; there was also slight rise of temperature, 99.5° F., and some acceleration of the pulse—84. In view of the family history, the physical signs in the lungs, the elevation of temperature and acceleration of the pulse, a diagnosis of beginning tuberculosis of the lungs was made. The patient was given creosote in increasing doses, was ordered to take plenty of nourishing food, and was given the well-known instructions ordered to patients with beginning pulmonary tuberculosis. No treatment was ordered for the throat. In four weeks the paresthesia disappeared, and, except for some slight recurrences, has not returned for two years. The patient is now practically well.

CASE II.—A woman, aged about twenty-six, came to me about four months ago. She was sent for an examination of her throat. She complained of pain in the throat for about three months past, with some cough and occasionally spasmodic contractions of the muscles of the larynx and neck, so that she sometimes had difficulty in breathing. This was, however, only momentary. The pain and “drawing,” as she termed it, were not constant, nor were they always on the same side. Sometimes these symptoms disappeared for a week at a time, when the cough also disappeared with the pain and contractions. The physician who had sent her to me had made an examination of the lungs, but had found nothing abnormal. I also

found no abnormality. The throat was absolutely normal; there was not even anemia of the structures. After much questioning the patient remembered that some distant relative of hers had died of tuberculosis. To do something I gave the patient creosote in moderate doses, four grains per day. So as not to prejudice her mind, I told her that her throat-affection was a nervous trouble and would probably last a long while. Two weeks later the patient informed me, without any interrogation on my part, that the paresthesia was considerably improved. I increased the dose of creosote to six grains daily, and four weeks later the patient informed me that while the paresthesia was still occasionally present, it was much improved. The patient has gained in weight, looks better, and has a better appetite.

In brief, then, the cases of paresthesia of the throat which are premonitory of tuberculosis of the lungs are characterized principally by uncertainty on the part of the patients as to the cause and the time of beginning of their symptoms. Then in cases of anemia of the throat, in combination with the paresthetic symptoms, this condition should be thought of, although, as I shall mention later, anemia of the tissues of the throat is not an absolutely necessary condition in this class of cases.

This condition should also be suspected in all cases in which the patient has the well-known *habitus phthisicus*, or in which there is a tuberculous family history, and finally in all cases which cannot be definitely traced to an injury of the mucosa, or which are not positive types of the hysterical or hypochondriac varieties.

As regards the pathology of this affection we must honestly say "ignoramus." We do not know the reason why in the beginning stages of tuberculosis of the lungs there should be these peculiar nervous manifestations in the throat. Jurasz has attempted an explanation and calls these paresthetic manifestations "reflexempfindungen" (reflex sensations). He explains their causation by transference of the irritation produced by the pulmonary changes on the sensory fibers of the nerves in the lungs to the centripetal fibers (*i. e.*, the sensory fibers) of the pharyngeal and laryngeal nerves. He says that this theory is rendered plausible by the fact that these fibers are branches of the same nerve, the pneumogastric, which, it is well-known, distributes sensory fibers both to the lungs and to the pharynx and larynx, and also motor branches to the muscles of the latter. This attempted explanation is still an unsubstantiated theory, and, while very probable, we must confess that we do not to-day know the true reason for the presence of paresthesia of the throat in the early stages of tuberculosis of the lungs.

Gottstein lays stress upon his observations that all of these cases occur in anemic conditions of the

pharynx and larynx, and hence he considers the paresthesia as a tropho-neurosis. This certainly does not hold good in all cases, for Jurasz declares that there are cases of paresthesia of this kind in which there is absolutely no anemia, and that it occurs in the very earliest stages of tuberculosis of the lungs, in cases in which positively no abnormality can be detected by the most careful examination—and which later by their history proved to be cases of pulmonary tuberculosis—and in which there had not yet been sufficient time for the anemia of the throat to have supervened.

I can corroborate this statement, for in the second case here detailed there was absolutely no anemia of the throat and no apparent abnormality in the lungs. Still I am convinced that this is one of those cases of paresthesia accompanying the initiatory stage of pulmonary tuberculosis, in which the changes in the lung-tissues are so slightly developed as to escape detection by our present methods of examination.

If we feel convinced that the paresthesia is due to or accompanies the initiatory stage of tuberculosis of the lungs, the prognosis is generally favorable. That is to say, if the pulmonary pathologic conditions can still be inhibited or made to disappear by appropriate treatment, the paresthesia will in time disappear in the great majority of cases. Still there are some cases which will persist in spite of any and all treatment. As regards the treatment, local measures should be entirely discarded. They are of no avail, and it is simply a waste of time and energy to persist in their use.

It would be "like sending owls to Athens" were I to attempt to bring forward any arguments to-day in behalf of the employment of creosote in the treatment of tuberculous affections of the lungs, especially in the early stages. I have seen most excellent results in quite a number of cases of tuberculosis of the lungs in their early stage from the administration of creosote, and I consider it the remedy *par excellence* in these cases, both uncomplicated and complicated with throat-affections.

I consider the paresthesia of the throat as one of the complications of pulmonary tuberculosis, even in those cases in which no physical changes can be discovered in the lungs by auscultation and percussion, and I would advise the use of creosote in gradually increasing doses as the remedy that to-day gives the best results in these cases.

To recapitulate: Paresthesia of the pharynx and larynx is not a rare accompaniment of the early stages of tuberculosis of the lungs. In those cases in which no physical signs can be found in the lungs, it should be considered a premonitory symptom of tuberculosis of these organs: (1) if there is tuberculous family history; (2) if the paresthesia cannot

be definitely traced to a foreign body, or an injury produced by such an agency, or by the swallowing of some hard substance; (3) in the cases of imaginary foreign bodies of indefinite etiology, with the presence of anemia; (4) in all those cases which cannot be positively placed under the head of hysteria or hypochondria. Finally, these cases are best treated by the internal administration of creosote, without the use of any local treatment.

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## CLINICAL MEMORANDA.

PRELIMINARY NOTE ON THE PRONOUNCED  
EFFECT OF THE ENDERMATIC USE OF  
GUAIACOL IN CONTROLLING HIGH  
TEMPERATURE IN TUBERCULOSIS.

BY J. SOLIS-COHEN, M.D.,  
OF PHILADELPHIA.

HAVING noted remarkable statements in the French journals as to the antipyretic and other effects of guaiacol used endermatically in tuberculosis, and having had my attention called to the statement about the same time by a medical friend with whom I was seeing a case in consultation, we determined to try the method in that instance. The result was marked, and the case will be duly reported by the physician in charge.

Then the same treatment was tried under my directions upon two of my cases in the Home for Consumptives at Chestnut Hill. The result was very encouraging, as will be seen from the following record, chiefly from notes by the resident physician, M. Hannah McKirachan.

CASE I.—Mrs. F. September 3d, 3 P.M., temperature 102.4°. Guaiacol,  $\mathfrak{M}_{xxx}$ , was well rubbed into the skin over the cavities for eighteen minutes. 3.33 P.M., temperature 99.3°. 5.00 P.M., temperature 97.4°. The patient was perspiring copiously, especially in the groins. The pulse was good, the body warm. 6.15 P.M. The patient was chilly, the finger-tips blue and cold. Heat was applied to the extremities. 6.35 P.M., temperature 97.4°. Then the temperature gradually rose to a little above normal.

The patient felt well and looked well and bright when I saw her the next day. She had not been as near collapse as a patient in private practice had been reported a few days previously. She described the cold feeling as having been similar to that following the evaporation of the vapor of menthol from the skin. Her appetite was good. Her cavities, for the moment, were dry. The

temperature did not rise to 102° again for several days, and when it was noted, September 9th, 3.00 P.M., it was 102.4°. Guaiacol,  $\mathfrak{M}_{xxv}$ , was painted over the cavities with a camel's hair pencil for fifteen minutes until it was all apparently absorbed. 3.30 P.M., temperature 102°. 3.45 P.M., temperature 101°. 4.00 P.M., temperature 97.4°. Pulse was good. Perspiration was free. No sign of tendency to collapse. Again there was freedom from excessive rise of temperature for several days. September 14th, 3 P.M., temperature 103°. Guaiacol,  $\mathfrak{M}_{xxv}$ , was painted over the cavities. 3.30 P.M., temperature 101.6°. Perspiration was free. 4.00 P.M., temperature 100.2°. 4.30 P.M., temperature 99°. 4.50 P.M., temperature 97.4°. 5.30 P.M. The patient was feeling comfortable, and went to the dining-room for supper.

CASE II.—Mary F. September 12th, 2.10 P.M., temperature 102.4°. 2.45 P.M., guaiacol,  $\mathfrak{M}_{xx}$ , was painted upon the skin over the diseased portion of the lungs. 3 P.M. The patient was perspiring a little, especially about the head. 3.25 P.M., temperature 101°. 3.40 P.M. Perspiring profusely. 3.56 P.M., temperature 101°. 4.00 P.M., temperature 100.2°. 4.30 P.M., temperature 99.2°. 5.00 P.M., temperature 99°. 5.15 P.M. Slight chill. Heat was applied externally. Temperature 99.4°. 5.40 P.M., temperature 99°. Lips blue. 6.35 P.M., temperature 99.8°. Patient was very sleepy.

It is noteworthy that such marked effects are produced by the endermatic use of guaiacol, when its internal administration and its injection into trachea and bronchi are not followed by similar effects.

Its use should be studied, and studied with caution that protects the patient from neglect in case of too sudden reduction of temperature.

The nurse in charge of the two cases noted, and Dr. McKirachan also, painted guaiacol on their own bodies to note its effect on normal temperature in the healthy subject. There was a slight chilly sensation half an hour afterward, but no sensible alteration of temperature on thermometric test. The guaiacol used in these two cases was not Merck's, but of American manufacture.

IMPERFORATE HYMEN, WITH RETENTION OF  
MENSTRUAL FLUID.

BY ADOLPH KAHN, PH.G., M.D.,  
OF SAN FRANCISCO, CAL.

ON the evening of July 4th, at 10 o'clock, I received a summons to attend Miss R. A., who, the messenger informed me, was suffering great pain in the abdomen, and also that something was protruding from her parts.

The patient, a well-nourished and vigorous girl of nineteen years, I was informed, had, about four weeks previously, a similar, yet not quite as severe an attack as the present one, for which she consulted a physician. The affection was pronounced "bowel-complaint," and the girl was ordered the "rest-cure" for one week, as she termed it—remaining in a recumbent position, subsisting on a diet of milk, rice, and toasted bread, with a tablespoonful of castor-oil each night. In a few days she felt comparatively free from pain, but the uneasiness in the abdomen and bladder still persisted, with frequent stools and painful micturition. On the 2d of July the abdominal pains returned, increasing continually, and while at



stool she became aware of the protrusion from her body. It was then deemed advisable on the part of the relatives to call a physician.

Upon examination, I discovered an abdominal tumor extending upward to the umbilicus, giving the girl an appearance of being about six months pregnant, and causing me to inquire when she had last menstruated. In reply, I was informed that she had never menstruated, and that late menstruation was a family feature. I then proposed to ascertain the nature of the protrusion, and found the anus in a normal condition. I endeavored to make a vaginal examination, but that was impossible, for the hymen proved to be imperforate, the membrane being distended and protruding, the labia separated to an extent of two inches, and the perineum bulging as if pressed upon by a fetal head.

The parents were informed of the nature of the condition, and that an operation would be necessary. For the night, the pains were calmed by an anodyne suppository. On the following day, at my request, Dr. C. E. von Hoffman saw the case with me. The membrane was anesthetized with cocain, and a small incision was made in the median line, giving exit to a dirty-brown fluid, of which about two quarts escaped, when it became semi-gelatinous, necessitating the removal of a piece of membrane to permit it to flow more freely, but it gradually became so gelatinous that it had to be carefully pulled out with forceps. At least two more quarts were removed by this process.

The operation was performed upon strictly aseptic principles. There was no subsequent elevation of temperature. The patient was kept in bed for a week.

The points of interest in this case are: The condition of the menstrual fluid evacuated, the gelatinous substance showing that absorption must have taken place; the rapid recovery of the patient, showing the small danger attendant upon the rapid evacuation of accumulations under strict aseptic procedure; and the mistaken diagnosis in the first place; also, the extremethickness of the membrane—one-eighth of an inch at least, when distended.

The patient has since had a normal menstrual period.

430 KEARNY STREET.

## MEDICAL PROGRESS.

*A Case of Focal Epilepsy.*—WHITE (*British Medical Journal*, No. 1700, p. 225) has reported the case of a woman, forty-one years old, who two and a quarter years previously had had the left breast removed for malignant disease, and who for some weeks presented numbness in the right hand. The day before coming under observation she had a convulsion, and subsequently about fifteen severe and a number of slighter fits every twenty-four hours. The attack was preceded by a sensation of numbness and tingling in the fingers and thumb of the right hand. In less than a minute afterward there followed a series of rapidly repeated extensions of the right wrist and metacarpo-phalangeal joints. At the same time there occurred a series of rapid abductions of the hand to the ulnar side. The next stage consisted of rapid flexions of the phalangeal and metacarpo-phalangeal joints, so that the fingers were dug into the palms

of the hands. Then there followed a series of rapid flexions and extensions of the elbow; after which the attack was over. Exclusive of the stage of numbness the whole attack lasted about ninety seconds. The minor attacks were much shorter in duration and consisted only in a little movement of the fingers. In a few, after the flexions of the elbow, the shoulder was, for a few seconds, rapidly adducted and abducted, and the head was jerked to the left. It was said that the woman was unconscious after the first attack, but in those personally observed consciousness was not lost. In the intervals between attacks, the right upper extremity was, in all movements, weaker than the left. The hand lay pronated and the supinators were unable to move it. With the right hand the dynamometer could be moved only to 50, while on the left it could be moved to 90. There was no paresis of the muscles of the head, face, eyes, tongue, trunk, or lower extremities. The knee-jerks and plantar reflexes were preserved and more pronounced upon the right than upon the left. There was no clonus at either knee or ankle. The elbow-jerks were abolished. The wrist-jerks were present, that upon the right being exaggerated. The woman was intelligent. Sensibility to touch, pain, and temperature was quite normal over the whole body. The muscular sense was normal. The fields of vision were normal, both for form and for colors. The pupils were equal and reacted well, and there was no ocular paralysis. There was optic neuritis at an early stage upon the right; the left fundus was normal. Smell, taste, and hearing were all normal. A diagnosis was made of a growth in the left cerebral cortex implicating the arm-area and secondary to the disease of the breast. The patient was willing to submit to an operation, and, accordingly, the middle of the fissure of Rolando was exposed. Over an area that, as nearly as could be judged, corresponded with the part of the arm-area in the ascending parietal convolution the cortex at one part was of a rather more brownish-green tint than normal. This part was cut away to such a depth that white matter was exposed. When frozen and cut this was seen to consist of new-growth. At the operation it was not definitely marked off from healthy gray matter, which it closely resembled. After the operation there was paralysis of the whole of the right side of the face, except the orbicularis palpebrarum and the occipito-frontalis. The tongue occupied the floor of the mouth and was quite motionless. The upper and the lower extremities upon the right side were completely paralyzed, but no sensory defect was noticeable. Aphasia was complete. After a time the right pupil became larger than the left, and there was sweating of the right side of the face, while the left side remained dry. The pupils later again became equal, and the ability to protrude the tongue returned, while the facial paralysis diminished somewhat. There was gradual diminution in the paralysis of the right side of the body. Some power of speech also returned. For the first three days after the operation the temperature was from  $1^{\circ}$  to  $2\frac{1}{2}^{\circ}$  above normal. Then it was normal till a week before death, during which it was from  $1^{\circ}$  to  $3\frac{1}{2}^{\circ}$  above normal; but at whatever figure it stood it was almost always higher in the right axilla than in the left. The difference was usually about  $1^{\circ}$ ; on one occasion it was as much as  $3^{\circ}$ . Sixteen

days after the operation careful examination showed that tactile and thermic sensibility and the power of localization were quite normal. About a month after the operation drowsiness appeared, with slowness of the pulse and cerebral vomiting, and in a short time death took place. On post-mortem examination it was found that the gap left by the removal of the diseased structure was limited in front by the fissure of Rolando, while posteriorly it extended slightly on to the supra-marginal convolution, its long axis just crossing the lower inter-auricular sulcus. The floor of the excavation was constituted of white matter, soft and discolored here and there, with shreddy filaments of growth. There were secondary deposits (all of which evidently had recently grown very rapidly) in the upper part of the ascending parietal convolution, in the posterior part of the third left frontal, in the upper part of the left angular, and in the middle of the right ascending frontal convolutions.

**Symphysiotomy.**—EUSTACHE (*Nouv. Archives d'Obstét. et de Gynéc.*, 1893, No. 7, p. 318) maintains that symphysiotomy may be considered as belonging within the domain of legitimate obstetric operations. It should not, however, replace the induction of artificial labor if the pelvic narrowing is detected in the course of the pregnancy. During labor it should be performed at once if the conjugate diameter is narrowed to between 3.1 and 2.3 inches. If this diameter exceeds 3.1 inches the operation should only be undertaken if it is not possible to terminate labor by means of version and the application of the forceps. In cases in which the conjugate is between 2.7 and 2.3 inches symphysiotomy ought to be performed in conjunction with the induction of artificial labor; and in most other cases with the application of the forceps.

**The Resuscitation of the Newborn.**—OEHLISCHLAEGGER (*Centralblatt für Gynäkologie*, 1893, No. 31, p. 718) points out that in many cases of asphyxia, especially in the newborn, the ordinary measures of resuscitation fail, because the entrance to the larynx is closed by the epiglottis from the falling backward of the tongue. If, therefore, under these circumstances the tongue be pulled forward the epiglottis is raised and air can enter the lungs. Such a result sometimes takes place spontaneously; at other times additional measures will be necessary. In cases in which the heart's action is embarrassed, compression of the precordium will sometimes stimulate the faltering organ. The skin may be pinched or the walls of the chest compressed rhythmically in synchronism with the heart-beat.

## THERAPEUTIC NOTES.

**A Case of Traumatic Tetanus Cured by the Antitoxin.**—GATTAI (*Centralblatt für Bakteriologie und Parasitenkunde*, Bd. xiv, Nos. 4, 5, p. 108) has reported the case of a girl, fifteen years old, who, while engaged in drawing, accidentally pricked herself upon the palmar aspect of the extremity of the right thumb with the point of a pair of compasses. The wound, which was attended with little loss of blood and occasioned little pain, was at once treated with a 10 per cent. solution of mercuric

chlorid and dressed with gauze and cotton. In the course of the same day and during the night the wound became painful, while the adjacent joint became stiff and a small pustule formed, while a line of bluish redness appeared on the dorsum of the hand. The pustule opened spontaneously, permitting the escape of a few drops of pus. On the following day the margins of the pustule were removed and the parts disinfected by means of mercuric chlorid. The pain, however, persisted and occasioned a good deal of annoyance, in the course of the next two days assuming a paroxysmal character. It was recommended that the hand be placed in a warm solution of mercuric chlorid with every exacerbation of pain, but on the following day the pain extended up the arm. An abscess formed upon the dorsum of the thumb and was freely incised, thoroughly curetted, and disinfected. Applications of cocain hydrochlorate failed to relieve the pain. In the course of the following days stiffness appeared, first in the lower jaw, subsequently to become general. Dysphagia and photophobia also manifested themselves and convulsions recurred paroxysmally. A diagnosis of traumatic tetanus having been arrived at, an injection of two drams and a half of blood-serum from an immunized rabbit was given, and subsequently upon the same day, at an interval of six hours, two injections, each of seven and a half grains of antitoxin obtained from the blood-serum of a dog, were given. These injections were continued in approximately like dosage for a week, amelioration in the symptoms meanwhile progressively taking place. On one occasion a dram of chloral was given by enema, and on each of several occasions fifteen grains. Under this treatment improvement steadily progressed, until on the nineteenth day after the puncture the patient got out of bed and resumed her ordinary pursuits.

**Bismuth in Large Doses for Chronic Gastric Catarrh.**—PICK (*Berliner klinische Wochenschrift*, 1893, No. 31, p. 761) maintains that, in order to be effective in the treatment of chronic gastric catarrh, bismuth should be administered in maximum doses. His own mode of procedure, which he reports to have practised successfully in a large number of cases, is to give a small quantity of a saline in about eight ounces of warm water before breakfast and half an hour later from three to four drams of bismuth subnitrate in two equal parts in cachets. Massage of the epigastrium is then practised for a short time, and in half an hour the patient is permitted to breakfast. Ordinary care is to be exercised with regard to diet. In mild cases decided improvement is said to follow after a week of this treatment; in the graver cases three or four weeks elapse before a similar result is obtained.

**The Utility of Electricity in the Treatment of Hemiplegia.**—RENZI (*Revista clinica e terapeutica*, 1893, No. 1, p. 1; *Gaz. hebdomadaire de Méd. et de Chir.*, 1893, No. 29, p. 345) contends that electrotherapy is sometimes immediately followed by a restoration of the power of voluntary contraction in the paralyzed muscles. This restoration is not dependent directly upon the electricity, but upon the contractions induced, the memory of the defective motor mechanism being thus revived.

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SATURDAY, SEPTEMBER 30, 1893.

## THE LAY-PRESS AND MEDICAL ETHICS.

CONCERNING questions of taste, the oldest proverbial wisdom tells us that dispute is useless. In reference to the criticism of MR. ERNEST HART's recent American addresses it is therefore amusing to notice with what unanimity and avidity the quacks, potential or actual, and their lovers, seize upon possible errors of fact the most trivial in order to make them excuses for rage against principles they hate, but which they hardly dare confess that they hate. Among a certain class of physicians, stung by MR. HART's truths, it is delightful to see how gossip and scandal and condemnation of matters of taste are rolled as sweet morsels beneath the tongue, and this by men whose urbanity of deportment and exquisite sense of the fitting are quite as wofully illustrated as by a freshly imported South Sea Islander.

There are few medical men so bold as to defend the newspaper doctor, the self-advertiser, the fellow who furnishes the reporters with his own photographs and reports of operations, or who goes into the secret-nostrum business. An occasional man, with a degree of M.D., may possibly become such an *advocatus diaboli*, but it would be altogether too ludicrous to call him a *medical* man. But the concealed malevolence can expend itself in well-

simulated horror at supposed lapses of good taste and thus run tilt against the red-rag of manners in order to lose in mad action the pain of the deft matador's burning darts. The service MR. HART has rendered us, however indirect, is excellent: he stimulates the secret enemies within the profession to show themselves and to range themselves where they belong—that is, with their friends the patent-medicine-fed, notoriety-seeking, nostrum-loving newspapers. There is a deal of ducking and dodging about it, of course, and we have some fine farcical touches now and then—medical Falstaffs, for example, attempting the rôle of auctioneers of their own virtue, and not getting a single bid.

But there are friends who are not compelled to whip up subterfuge or factitious indignation: these are the dear newspapers whose pocket-books are touched, whose very financial existence, indeed, depends upon crapulous advertisements and the money of the nostrum-vender. These may loudly bawl their hatred of anyone who shall pretend to criticise the infamous traffic upon which depends their daily bread—*Wessen Brod Ich ess', dessen Lied Ich sing'*,—and so from one land's end to another the venal newspapers whose ten columns are filled with filthy advertisements of nostrums, "patent" medicines, and obscene literature, find room in the one or two remaining editorial columns of their space (also for sale, if desired!) to abuse MR. HART because he thinks the newspaper doctor and the nostrum-traffic quite contemptible. With editorial ink that stinks of the advertiser's skunkery, the didactic editor writes against the plucky Englishman, his antediluvian ethics, and his ancient prejudices.

One example of many such is an editorial in a recent number of the *Pittsburg Post*, entitled "Antiquated Conceits," in which MR. HART and the "old school" are lectured as if by a demigod of wisdom and virtue for their "intolerance," "medievalism," "obsolete traditions," "despotisms," and all that, and are told that all this has long since passed away with other thousands of effete superstitions and shams. "Professional etiquet and ethics" are spit upon quite contemptuously, and the day of progress, of money-making by medical trickery, by nostrums, and, egad! by the newspaper, is dawning, to the everlasting shame of worn-out and antiquated medicine.

Now, if a healthy stomach can control a healthy



tendency to vomit when compelled to smell such an odious mess as this, it is of course quite amusing—much as would be a sermon by BOSS TWEED on civic virtue. But repeated from a thousand newspapers it grows too intolerably wearisome, and indignation wishes that a DANTEAN circle of the Inferno might be awaiting these righteous and progressive editors who thus prostitute their office for gain, and that for two eternities they had to swim in lakes of their advertisers' bitters, blood-purifiers, and panaceas, with no food but their advertisers' "little pink pills," and "Gentlemen's Friend" ("with a syringe free"), and no literature but their advertisers' "marriage-guides," and "retired clergymen's" secrets.

There are, thank Heaven! a few lay-journals that from principle and very shame refuse to fatten on humbug, and to sell their editorial souls, to the beguiled public's undoing. To these honorable exceptions we would appeal that they seek by every means, and on every possible occasion, to arouse in the public mind some true conception of the real state of affairs as regards the animus and doings of the medical profession, and as regards the animus and doings of the foes it has to withstand. It is extremely difficult to maintain a pure ethical ideal, and unselfishly to devote life for the benefit of those who not only are ungrateful, but who spew malice and abuse on their would-be benefactors.

In individual medical ethics and in their application in private life by the great body of the profession, there is a clearness of intellectual perception and a heroism of patient endurance unequalled by that of any body of men. But it is the united and corporate action that fails. And never in history did the public welfare more clearly depend upon anything than upon this purity of medical character and conduct, whilst at the same time foes within and foes without the profession are insanely seeking to destroy what is infinitely precious to that profession, but more precious still to a public that is stupidly regardless of its own highest interest, and of its own best friend.

At a certain physiologic season the female canine sends her volatile messages through miles of air, and the responsive friends never fail. The newspaper reporters also never miss the challenge of the newspaper doctor. But the newspaper doctor knows no estrual season—which is equivalent to saying that he is the professional prostitute. If it be said that owing to his sex the simile does not hold, the answer is

prompt that there is a terrible revival nowadays of pederasty.

It is as natural for a newspaper to espouse the quack's side of medical scandal as it is for a gambler to defend horse-racing. If a rascal concocts some dodge for making a fortune by "curing" drunkards, for reviving the waning powers of *roués*, or for giving brain-power to the brainless, nine out of ten newspapers will give thousands of dollars' worth of free advertising to the schemes, and laud the "gold cures," "testicle juice," or what not else, to offended heaven. A Philadelphia newspaper lately made itself the agent of some patent medicine cure-all, and distributed thousands of bottles over its counters.

There remains, of course, the humiliating confession that the existence of the newspaper doctor and of the newspaper debauch in quackery is indirectly and in large part the fault of the profession itself, dependent upon the fact that we are a non-organized profession, and that what organization we have is not used in the practical righting of medical abuses. Thus, again and perpetually, recurs the truth that every medical scandal and every aspect of our powerlessness resolves itself into our sins of disorganization and of non-interest in practical matters and in preventive medicine. Out of a hundred thousand physicians in America hardly a hundredth part are active members of the American Medical Association, and the section meetings of "congresses" of physicians could almost always be held in an ordinary private sitting-room of a workman's cottage—so slim is the attendance. And when we do meet we discuss the symptoms and treatment of individual cases of illness, leaving out of consideration the production of disease, the prevention of it, and the domination of legislation, the newspapers, and the lay-world by the quack and the pill-vender.

How can we bring any influence to bear upon the newspapers if we present the spectacle of a disunited and factional lot of scramblers and indifferentists? There are many of these newspapers that are simply ignorant and thoughtless as regards the disgrace of their advertising columns, and who could easily be shamed out of it if we were but united among ourselves, and would use our united strength for matters of practical reforms of medical abuse and preventive medicine. Organize, and use organization for the world's sake! is the command of professional honor and of benevolence.

It may be said by the lay-journal that we as a

profession have no right to complain so long as so-called medical journals trade in nostrums, and so long as once reputable medical journals loan their columns to the defence of masked quackery, and to the abuse of critics of medical disgrace. The retort is pointless. This is a question like one of national finance, outside of parties, and all good men of whatever calling must unite to crush the control of the press by patent-medicine syndicates, and to aid the better part (which, despite appearances, is by far the greater part) of the medical profession to keep its character and standards above the smirch of a rotten commercialism. Reputable and self-respecting newspapers should combine to limit the national crime and disgrace of the newspaper debauch in advertisement filth and fraud.

## SOCIETY PROCEEDINGS.

### AMERICAN DERMATOLOGICAL ASSOCIATION.

*Seventeenth Annual Meeting, held at Milwaukee, Wis., September 5 and 6, 1893.*

#### FIRST DAY—SEPTEMBER 5TH.

##### *Morning Session.*

THE Association met in the club room of the Pfister House and was called to order by the President, Dr. George Henry Fox, of New York, at 9.30 A.M.

DR. R. B. MORISON, of Baltimore, Md., read a paper entitled "Cosmetics." Cosmetics, in a general way, may be divided into two classes, namely, those that are irritating and those that are soothing. For instance, if we wish to remove freckles or warts, a stronger application must be made than if we simply prescribe for a redness following an acne or an eczema. The patient, either through himself or his assistant, should be taught how to apply local remedies. Salves, plasters, lotions, and caustics are so often misapplied that experience had taught that an application from which one hoped to get the most good must be made by skilled hands. For the removal of freckles the following solution was recommended:

R.—Corrosive sublimate . . . . .	gr. vij.
Distilled water . . . . .	3vj.
Spirits camphor . . . . .	3ss.
Rose-water . . . . .	3v.

Three or four thicknesses of linen, cut to cover the seat of freckles, are moistened with the solution and placed upon the face at night until they dry, when they are taken off. Whatever remains on the skin is left there till morning and then washed off. After a few nights' application the face becomes red, and the epidermis begins to peel off in fine scales. Then an ointment is used night and morning, the application being made by gently rubbing it over the face for five minutes at a time with a clean finger.

In the removal of superfluous hairs, the author has given up electrolysis. He finds that the proper applica-

tion of a good depilatory answers the purpose much better. There are many women who wish to get rid of the white lanugo down on their faces, upon whom it seems that electricity cannot be used for fear of stimulating the growth of the surrounding hair, and the appearance of permanent scars. If a preparation of yellow sulfate of arsenic and quicklime, of equal parts, made into a paste with hot water, be allowed to dry on the hairy skin, it removes the hair for ten to twenty days, and sometimes permanently. On the other hand, nothing seems to take the place of electrolysis when there are a few strong hairs growing from moles, in the removal of moles themselves, in angioma, or in permanent small red spots.

For the removal of warts the author prescribes the following:

R.—Hydrarg. bichlor. . . . .	gr. v.
Acid. salicyl. . . . .	3j.
Collodion . . . . .	3i.

He sometimes increases the mercuric chlorid to 30 grains in the same amount of collodion, if the milder application does not answer. It is applied every day once, the upper crust of the previous application being removed before a fresh one is made. Four such applications generally soften the wart to such a degree that gentle traction removes it painlessly, the further dressing being any simple ointment.

The author had obtained excellent results in cases of acne by the use of the galvanic current.

DR. GEORGE T. JACKSON, of New York, read a paper entitled "A Case of Rhinoscleroma," in which he said that in October, 1892, he had the pleasure of presenting to his class at the Woman's Medical College of New York Infirmary a case of rhinoscleroma. There have been only three cases of this disease reported by members of the American Dermatological Association since its foundation, in 1877. The patient, a woman fifty-four years of age, was born in Hungary. The disease began sixteen years ago as a slight thickening of the upper lip to the left of, and just under, the septum nasi. Since then it has grown slowly and without pain. During the past four years it has increased in size more rapidly than during the preceding twelve years. At present it appears as a hard, well-defined, elevated, old-ivory colored mass, located upon the upper lip, beginning at a point a little to the right of the middle line and occupying nearly the whole of the left side of the lip. It runs up upon the left side of the septum nasi to a slight extent. It is slightly lobulated, so that it has an uneven surface, and shows a number of dilated bloodvessels running over it, and a number of white points apparently representing plugged-up and dilated follicles. There is no history of syphilis, nor does it look like a syphilitic growth. There is no sign of ulceration and no tendency to break down. Only about 100 cases of the disease have been reported altogether.

No satisfactory treatment of the disease has been found. The best results so far reported have been attained by the use of salicylic acid, injected into the tumor daily, a 1 per cent. solution of the acid or a 2 per cent. solution of sodium salicylate being used, while ten grains of the acid were administered by the mouth three times daily.

"A Case of Circumscribed Scleroderma (Morphea)" was the title of a paper read by DR. W. T. CORLETT, of Cleveland, O. Mary M., ten years of age, an intelligent-looking girl, well nourished, although slightly pale, presented herself with variously sized and colored lesions on the left upper extremity. These were of two years' duration. The lesions were located on the extensor surfaces, the most typical lesion being situated on the middle third of the forearm. This was of oblong shape, four inches in length and two inches in width. It was slightly contracted, lessening somewhat the circumference of the forearm, and was somewhat depressed, resembling cicatricial tissue. The lesion presented a yellowish-brown central area, with a slightly uneven surface, slightly indurated, and non-adherent. There was no anesthesia. Hairs were absent. Outside the central zone was a bluish-white area surrounded by a lilac-pink border merging into normal skin. The veins about the lesion were very prominent. A second spot had appeared one year after the first on the back of the hand, the characteristics of which were similar to the preceding. During the four months prior to her first visit to Dr. Corlett seven other spots appeared on the arm and one on the shoulder. These were smaller than the original. Sharp pains were now complained of, extending from the shoulder to the hand. These were aggravated by writing, but lasted only a few days. Some itching around the margin of the lesions and, occasionally, frontal headache were complained of. There was tenderness over the upper dorsal and lower cervical vertebrae; but no motor or sensory impairment anywhere; nor was there any other evidence of cord-disease. There was no history which might possibly explain the lesions, excepting a fall upon the back at the age of five years. There was no history of nervous or hereditary disease of any kind in the family. The case was originally considered as a perfect type of morphea, but at the present time it presents a picture of the atrophic stage of scleroderma.

The points of interest are:

1. The changes of clinical form through which the disease has passed.
2. The predominance of the neurotic element, which is so often well-marked in morphea, and which points to the spinal cord as the most probable seat of the disturbance.
3. The confusion of nomenclature of morphea and its relation to scleroderma is of some interest. Modern treatises on dermatology by American authors are in the main inclined to consider morphea and scleroderma as distinct affections, while European authorities are rather inclined to the opposite view.

DR. W. A. HARDAWAY, of St. Louis, Missouri, read a paper entitled "A Case of Tuberculosis of the Skin Simulating Lupus Erythematosus." The patient was a pharmacist, twenty-eight years of age; whose previous health and family history were good, and who presented no history of tubercle. He is tall and spare, and of sallow complexion, yet a man of great endurance. In May, 1892, he noticed in his left malar region a small yellowish elevation the size of a pin-head. This was supposed to be a flesh-worm, and was squeezed, blood only being thereby obtained. The lesion gradually enlarged peripherally, becoming hard and red, but was

unattended with subjective phenomena. He came under Dr. Hardaway's care in June, 1892, the lesion being now as large as a dime, and presenting an atrophic whitish center surrounded by a slightly raised infiltrated border of a dull-red color. The lesion was anesthetic, a characteristic which has been noticed in tubercular syphilides. The anesthesia was temporary. In a short time the patient passed from under observation and was gone for a month, during which time he was thoroughly treated for syphilis by another physician. The treatment simply aggravated the general and local conditions. On September 3, 1892, the original lesion was the size of a half-dollar, not raised from the surface, and moderately infiltrated. The center was still atrophic, and the same narrow dull-red line presented at the borders. In a few weeks several small acniform pustules appeared on the right temple, the side of the nose, and the inferior angle of the right eye. Others presented at the end of the nose, on the right ala, and left cheek. These lesions were not painful or itchy. Each lesion was surrounded by a red areola, which subsequently extended and became infiltrated, crusts forming over the centers of the lesions. The crusts were fatty or sebaceous in character, and with a dull-red surface beneath were suggestive of lupus erythematosus. As the borders of the lesions extended the centers cicatrized, presenting the same dirty-yellow appearance of the original patch. Early in January a small piece of skin was excised from the lesion on the right temple and examined microscopically. Electrolysis was tried upon the other lesions with an apparent cure, followed by a relapse after a few months, manifesting itself first by the formation of a scale in the center of the scar. Electrolysis was persisted in as fast as the spots appeared and with apparent success. In March a small patch similar to the others appeared upon the scalp, and this is now the size of a dime. The tendency to peripheral extension throughout has been a marked feature in this case. The whole nose finally became involved and became a continuous lesion of partly red and partly cicatrized integument, presenting a striking likeness to some forms of lupus erythematosus. At no time could nodules of lupus vulgaris be demonstrated, nor were the sebaceous plugs of lupus erythematosus seen at any time. The patient's general health has continued so poor that at one time general tuberculosis was considered imminent. A trip to Colorado brought about great improvement. At last accounts the disease was apparently quiescent, the patient's general health good, and no lesions of the lungs and larynx have been detected. Dr. C. Heitzmann reports, after microscopic examination of the excised piece of skin, that a moderate number of tubercle-bacilli were found. A large number of inflammatory corpuscles were also detected displacing the fibrous connective tissue. Nests of inflammatory corpuscles were seen in the arrangement characteristic of tuberculosis. The diagnosis was local tuberculosis of the skin, which was entirely in accord with the clinical diagnosis.

DR. H. R. CROCKER, of London, England, read a paper on "Lupus Erythematosus as an Imitator of Various Forms of Dermatitis." The author said that lupus erythematosus as an imitator of various forms of simple dermatitis was a formidable rival of syphilis itself. It was to this aspect of the disease that he desired to direct



attention by relating some cases and showing drawings which illustrated the points he wished to place before the Association.

The first drawing was an instance of a lupus imitating erythema tuberculatum. The patient was twenty-seven years of age. The lesions commenced on the right cheek. There was only one spot for the first two years; then others formed on the side of the nose, and they then became scattered irregularly over the face, but with the exception of a hempseed-sized nodule on the left ear, there was none anywhere else. The lobes of both ears appeared atrophied, but the patient said there had never been any lesions on them. All the lesions were exactly like those of erythema tuberculatum, varying from the size of a hempseed to a half-inch in diameter, quite smooth, except one on the side of the nose, which was scaly. They were of a uniform purplish-red, except one, which was whiter in the center.

Case 2 showed an advanced condition of the disease, which began in a similar form to Case 1.

Case 3 was one of lupus erythematosus like erythema papulatum. The patient, aged forty-two, was a cab-driver. Two years previously he had some rash on the cheeks which lasted only a month, and it was not until a year ago that the present eruption began on the sides of the cheek, and has gradually extended until it reached its present condition. The eruption when seen occupied the whole face below the eyebrows, the orbits themselves and the lower lip escaping, but the chin, except in the center, was affected. On the left side it extended above the brow, but below the orbits, and was remarkably symmetrical. The most recent lesions were on the lower part of the side of the face and below the jaw. In these positions they assumed the form of erythematosus, slightly raised discs from a half to a quarter of an inch in diameter; the most recent were quite smooth and slightly convex; the larger ones were not prominent in the center and but slightly scaly.

Case 4 was like diffuse erythema, the patient being a lady, forty-three years of age. The disease had commenced three years previously as a small red spot on the side of the nose and had spread continuously. The whole nose was intensely reddened and slightly scaly; the skin thickened and infiltrated, but the orifices of the sebaceous glands were not plugged.

Another disease which lupus erythematosus imitates is psoriasis, and the author reported a case in point. A rarer imitation is that of lichen planus, of which the author has seen only two cases.

DR. CROCKER also reported a case of lupus erythematosus nodulatum. He had met with three or four other cases of this, but not with so many distinct foci of disease. In two cases there was only a single nodule in each. He also remembers a case in which there were even more foci of disease in a patient of the late Dr. Tilbury Fox. Cavafy also showed a case at the Dermatological Society of London, in 1892, but Dr. Crocker was not aware of any other cases having been recorded.

DR. E. B. BRONSON, of New York, followed with a paper entitled "The Treatment of Pruritus." The author said that in the management of *pruritus essentialis*, as of any other disease, the first consideration should be directed to the cause. The adoption of measures tending to remove any accidental conditions or influences through which

pruritus might be occasioned is important. Such causes include, besides various local sources of irritation, certain remote or general diseases and furnish the *indicatio causalis* in its more limited sense. This, however, states the scope of the problem only partially. What is of more importance is to establish principles of treatment fitted to those more special and more essential causes that constitute the necessary conditions of the disease and whence we derive the *indicatio morbi*. These causes are traced under etiology, and it is they which must afford the only intelligent basis for the therapeutics of pruritus.

The chief underlying condition in pruritus is hyperesthesia, whether in its common significance of an excessive irritability of the sensory nerves, or in the sense of an excess or engorgement of sensation. The prime indications then are to allay irritability and to divert or annul the excess of nervous excitement. Measures to remove local excitants include, first of all, such as directly tend to prevent scratching. To admonish the patient to refrain from this is usually of little avail. Restraint may be possible during waking hours, but at night, when the trouble is always at its worst, and especially during the state of somnolence midway between sleeping and waking, no power can prevent it. It can only be avoided by first mitigating the lesion through the aid of anti-pruritics. Sedatives used internally are likely to be disappointing. The degree of general sedation that is required to affect the nerves of the skin in so intense a disturbance as pruritus often is affords a sufficient reason why this method of treatment is usually objectionable. Further than this, the depressing and atonic after-effect on the nervous system tends to exaggerate the general hyperesthesia, which is already essentially an atonic condition, and thereby increases the tendency to itching. Especially objectionable are most of the narcotics. The bromids, on the other hand, are often indispensable and may be required in liberal doses. It is important to avoid the enervating effects of loss of sleep, and for this purpose sulfonal or some other hypnotic is occasionally needed. In connection with this, two internal remedies, which have been especially recommended by Bulkley, are worthy of mention, and they are cannabis indica and gelsemium. The former is known to be a cutaneous anesthetic as well as an analgesic, and by virtue of the former quality should be useful in pruritus.

Carbolic acid is the most reliable and most generally useful anti-pruritic which dermatologists possess. It was well named by Unna "the opium of the skin."

The following "anti-pruritic oil" has been much employed by the author for years both in local and so-called universal forms of the disease, with no more untoward results than now and then a trifling dermatitis, when through oversight the patient has been allowed to make the applications too frequently; or has continued them too long. The formula is:

R.—Acidi carbolic . . . . . 3j-ij.  
Liquor. potass. . . . . 3j.  
Ol. lini . . . . . 3j.—M.  
Sig.—Shake before using.

To correct the disagreeable odor of the linseed oil a drop or two of the oil of bergamot may be added. Sali-

cyclic acid and salol, though less energetic in their effects, act similarly to the carbolic acid. Thymol is also an admirable anti-pruritic, but on account of its irritating effect cannot be used when the skin is sensitive.

The author then dwelt on sensory stimulants, substitutive irritants, alteratives of cutaneous nutrition, and motor depressants. In pruritus hiemalis an all-important measure of treatment is protection against cold. The sole cause of winter pruritus, aside from a special predisposing hyperesthesia, is lowered temperature.

DR. JOSEPH ZEISLER, of Chicago, Ill., read a paper entitled "Angiokeratoma," and reported the following case: The patient was a German, and fifty-three years of age, butcher by occupation. Had never had any severe illness, but had had malaria once. His present illness began somewhat gradually about four years ago with red spots and verrucæ on the skin of different parts of the body. He was under medical treatment and says he improved for a time. He states that some of the red spots gradually disappeared at times, but returned, and new ones arose in different localities. During all this period his general health had not suffered in the least. No anorexia, headaches, nor any other complaint existed. There is no pain or itching in the skin-lesions. Patches of vitiligo of large size are found on the front and sides of the abdomen and on the right side of the thorax, and some small patches in the right axilla, with faint patches on the right side of the chest posteriorly and on the neck. There are also large patches on the penis and scrotum and small ones on the inner surface of the thighs. There are some old marks of tinea favus on the scalp. Nevus-like spots and small tumors are scattered over the body. The patches vary in size from three or four inches in circumference to the size of a dime. They are red in color, vascular, and slightly raised above the level of the surrounding skin. On the right forearm are numerous small tumors, varying in size from minute spots to some the size of a hazel-nut. The larger ones are all pedunculated, firm, and vascular. There is considerable edema of the right hand and fingers. Microscopic examination was made by Dr. Zeisler. Some of these tumors sprang out from beneath the finger-nails. On the left hand the verrucæ were not so numerous and inclined more to the small vascular variety, with two exceptions. Large irregular red patches were also found over each patella, and a few smaller ones irregularly scattered over the anterior aspect of the legs and thighs; also a few smaller ones over the posterior aspect of the thighs and one on each ankle. Two small pedunculated warts were also found on the back of the right leg, another with some of the red patches on the nates near the gluteal fold. No patches or tumors were found on abdomen, thorax, or upper part of arms.

The author reported this unusual and interesting case to show that the clinical picture of the disease is evidently not yet quite complete, and hoped that new examples of the disease would arise which would throw more light on the pathology and etiology of the affection.

DR. J. A. FORDYCE, of New York, read a paper entitled "A Contribution to the Pathology of Acne Varioliformis (Hebra)." Dr. Fordyce called attention to the case described by Dr. Bronson and himself in 1891, under the title of "Acne Varioliformis of the Extremities," which was at that time shown to originate in or

about the coil glands. This was identical with cases since reported by Politzer, Dubreuil, and others under the name of Hydradenitis, and should go on record as an example of that affection. While clinically it presented many points of similarity to acne varioliformis (Hebra), its pathologic anatomy was quite distinct.

The writer had examined microscopically a number of papules and papulo-pustules from two typical cases of the latter disease, and was able to trace its beginning to an inflammation about the middle and upper portions of the hair-follicles and their sebaceous glands, while the coil glands were shown to be outside the inflammatory area. Enormous numbers of staphylococci were found in sections from one of the cases examined which readily stained with Kühne's carbolic methylene-blue solution. These organisms were especially numerous about the middle and deeper portions of the hair-follicles, and were contained within the external and internal root-sheath, in the connective tissue about the coil glands, and in the subcutaneous connective tissue. In considering their number, distribution, and presence in the diseased area before the epidermis was involved, the writer was disposed to consider them a direct influence in producing the lesions. In a secondary infection they would scarcely be found at so early a period in the evolution of the papule.

As a result of his investigations, Dr. Fordyce concluded that acne varioliformis (Hebra) was an inflammation of the pilo-sebaceous system, of microbic origin, leading to destruction of these organs, and that Bazin was correct in naming the disease acne pilaris.

The members of the Association, at the close of Dr. Fordyce's paper, participated in a general discussion on pityriasis, rosea, and pemphigus.

The following officers were elected:

*President*—Dr. Robert B. Morison, of Baltimore, Md.

*Vice-President*—Dr. George T. Jackson, of New York.

*Secretary and Treasurer*—Dr. Charles W. Allen, of New York.

*Member-at-large of the Council*—Dr. J. A. Fordyce, of New York.

On motion, the Association adjourned to meet in Washington, D. C., in connection with the Congress of American Physicians and Surgeons, in May, 1894.

#### FIRST PAN-AMERICAN MEDICAL CONGRESS,

*Held at Washington, D. C., September 5, 6, 7, 8, 1893.*

(Continued from page 364.)

#### SECTION ON GENERAL MEDICINE.

##### THIRD DAY—SEPTEMBER 7TH.

DR. H. A. WEST, of Texas, read a paper entitled "Abstract Clinical Notes on Amebic Dysentery," in which he spoke of the practical importance of the subject in consequence of the diversity of opinion in regard to the definition, varieties, and etiology of dysentery, and especially the non-recognition by the general medical profession of the causal relations of the ameba coli in the production of dysentery and the wide dissemination and frequent occurrence of this form of the disease.

Attention was called to the following points:

1. Importance of a correct definition. Dysentery is not, as is usually taught, a morbid entity, consisting of an inflammation of the large intestine, essentially the same in all forms and climates, varying only according to climatic and other modifying conditions; on the contrary, the term dysentery should be used in a general sense to designate a group of inflammations of the large intestine partly of specific and partly of non-specific origin.
2. The adoption of the following classification will do much toward dissipating the existing confusion, viz., acute catarrhal, acute diphtheric, amebic, and secondary dysentery.
3. Amebic dysentery is more widely disseminated and occurs with greater frequency than is generally supposed.
4. To emphasize the probable entrance of the ameba through impure drinking-water.
5. To note the characteristic and uniform symptoms of this form of dysentery.
6. The essential chronicity and difficult cure depending upon the character and location of the lesions.
7. The necessity of combating the excessive anemia and wasting by the use of a more liberal diet than is generally prescribed.
8. To urge the importance of cleansing and antiseptic irrigations as a rational method of reaching and destroying the ameba, and stimulating the intestinal ulcers to heal.
9. To note the fact that while solutions of quinin are destructive to the ameba, injections of the same fail to exercise any marked curative effect.
10. The author's experience going to show that mild injections of nitrate of silver, thirty grains to a quart, with occasional administration of salines and large doses of bismuth and salol constitute the best treatment.

The nature of the disease is such as to produce very rapid anemia and wasting. It is necessary to combat these results by the plentiful use of nitrogenous food—meat, fowl, eggs, rich broths, milk, etc.; if restricted to a milk-diet these patients will very rapidly fail.

The character of the lesions gives the key to the most successful treatment, viz., consisting of thorough irrigation of the intestine, first with simple warm water for cleansing purposes; second, with an antiseptic solution for destroying the organisms and stimulating the ulcers to heal. For the latter purpose Dr. West has tried solutions of quinin, creolin, and silver nitrate; the latter has given the best results; quinin, in his experience, failing to accomplish any permanent good. While not attempting to explain the mode of action, large doses of bismuth subnitrate and salol seem to have had a distinct effect in controlling the excessive frequency of the stools. Salines also at times are beneficial, their mode of action probably consisting simply in a cleansing effect, in sweeping out irritants of various kinds.

DR. CARMONA, DR. GARDINER of Indiana, and others participated in the discussion, which was generally confirmatory of Dr. West's conclusions.

DR. J. W. McLAUGHLIN, of Austin, Texas, read a paper on "The Bacteriology of Dengue Fever," illustrated by photomicrographs of jelly-cultures of the

dengue-micrococcus. In closing the discussion on his paper Dr. McLaughlin said:

There is a very strong distinction between dengue fever and influenza, although there is a strong similarity. The cold weather kills dengue fever, which is without the catarrhal symptoms of influenza. While there is a resemblance, there is a marked distinction in the cause and in the disease itself. Dengue fever is to be regarded as distinctly different from influenza.

DR. F. G. NOVY, of Ann Arbor, Michigan, read a paper on "The Culture of Anaerobic Bacteria," containing a brief *résumé* of the principles and methods employed in the culture of anaerobic bacteria.

DR. NOVY also read a study of "A New Anaerobic Bacillus of Malignant Edema." In several guinea-pigs which died after injection of an impure milk nuclein solution a marked edematous condition was observed resembling, and even more pronounced than, that of malignant edema. In the subcutaneous tissues, peritoneal exudate, heart-blood, spleen, liver, etc., were found enormous numbers of a long slender bacillus. This organism was found to be obligative anaerobic in character, and pure cultures possessed marked infectious and extremely toxic properties, producing death in from twelve to thirty-six or forty-eight hours, with a characteristic edematous condition.

This new, highly pathogenic, anaerobic bacillus is motile and the flagella can be readily demonstrated by Löffler's method.

The germ is readily stained by simple dyes and also by Gram's method. Spore-formation has not been observed, but the germ itself is extremely resistant.

## CORRESPONDENCE.

### DR. HAMMOND AND THE MEDICAL PROFESSION.<sup>1</sup>

To the Editor of the *New York Medical Journal*,

SIR: My respect for and my sympathy with the medical profession in America, and my knowledge of its sentiments, forbid me to regard Dr. William A. Hammond as its representative in the defence which he puts forward in your columns of September 16th, of the practices of publicity-hunting by newspaper interviews, newspaper portraits, and of the use of and traffic in secret preparations, etc. I have in the course of recent travel received personally from many hundreds of prominent and representative physicians in Milwaukee, Washington, Boston, Philadelphia, Chicago, Cincinnati, Detroit, and from all parts of the United States, their cordial congratulations on the tone and substance of the addresses which I had the honor to deliver at Milwaukee and Washington. I have been assured on all hands of the entire sympathy of the great body of the profession in the views therein laid down and discussed. I should have been surprised, however, and perhaps disappointed, if they had not elicited some expression of pain and anger from certain quarters. "Let the galled jade wince, the withers" of the great American medical profession are,

<sup>1</sup> From an advance duplicate of a letter sent to the *New York Medical Journal*, kindly furnished THE MEDICAL NEWS by Mr. Hart.



I am assured, "unwring." Your correspondent, in an access of ethical agnosticism, assumes that the enumeration of ethical data as to medical conduct was or could be a reproval, direct or implied, to the medical profession of America. That is an unmerited insult which he addresses to his profession, and indicates a view which I apprehend to be special to himself. Let him enjoy the practices which he defends; I do not think that he is likely to find much support or sympathy in them from medical men in good standing. His account of the position of medical men in Great Britain is a parody undeserving of serious notice. So as to myself, whom he favors with some personal abuse, I have been avowedly the scientific adviser to, but it is untrue that I have ever held any of the stock of, the Apollinaris Water Company. As to his other trivialities, I was the guest of the Pan-American Medical Congress, and on entering its headquarters I registered in ceremonious form.

I have no desire to be honored amongst "the Pan-Americans," "the loyal legion," "the fat men of America," and the other objects of lay interest with whom Dr. Hammond puts medical men on a par, and I do not agree with him that medical men should desire to share with them the honor of newspaper notoriety. I do not believe any details of my medical career have ever appeared in any lay paper. I suggest that it might be desirable for Dr. Hammond to rely less upon his imagination for his facts, and not to assume to speak for a profession from which he has no sort of mandate, and which would, I am well assured, repudiate, if consulted, both his advocacy and his methods of action and of expression. I am assured that he utterly misrepresents that profession, both in his statement of principles which he ascribes to it, and in his abuse of myself.

I am, sir, yours faithfully, ERNEST HART.

#### CLINICAL NOTES ON RHUS TOXICODENDRON.

To the Editor of THE MEDICAL NEWS,

SIR: In an editorial comment in THE MEDICAL NEWS of September 9, 1893, attention is called to the use of rhus toxicodendron "in a large and ill-defined group of chronic rheumatic affections," and allusion is made to its usefulness in certain chronic skin-eruptions, in hemorrhoids, varicose veins, etc.

To Dufresnoy, of France, belongs the credit of first having observed the therapeutic effects of the drug. He quotes a case of a young man so severely poisoned by contact with the plant as to experience its constitutional effects, the result of which was the cure of an eczema of many years' standing.

From the time of this observation comparatively little account has been taken of its action by the regular profession, especially in this country. It is official in the German Pharmacopeia, and was recognized by the United States Pharmacopeia of 1830.

The "Eclectic" and "Homeopathic" schools seem to have retained it, and we find it and its ally, "rhus aromatica," entering into the composition of various proprietary eliminative mixtures.

A strange relationship seems to exist among its uses by the older men of the regular school, the eclectic, and the homeopathic professions. Among its "indications" in the therapeutics of the latter we find "*Rheumatic and*

*gouty* tension, joint and tendinous lameness, urticaria, heat spots, vesicular and scaly eruptions, nocturnal incontinence, etc."

Dr. H. G. Piffard, in speaking of its use in skin-affections, says: "I have seen prompt change for the better, I might almost say abortion of the eruption, follow the uses of small doses of rhus toxicodendron."

Dr. Aulde, of Philadelphia, also speaks of the value of small doses.

My personal experience with the drug dates back two years, and although I have used much larger doses (five to ten drops of the fluid extract) than those recommended, I have seen no evil effects, and can confirm its usefulness in certain painful conditions.

My attention was called to its use by a man who had tried in vain the various "pathies," and who had spent much time and money at Hot Springs, Arkansas, in a fruitless endeavor to rid himself of what had been diagnosticated as chronic rheumatism, and who, at last, to use his own language, had "found something that had made a new man of him, and would knock the rheumatism out of any man." This "something" was the fluid extract of rhus toxicodendron in ten-drop doses. I determined to give it a trial. My first case was that of a lady, of distinctly uric-acid inheritance and diathesis, who had gone the rounds of the iodids, alkalies, and salicylates with but little effect, and who now keeps a bottle of rhus toxicodendron as a panacea, claiming that she can always control her pain by it, and that she does not think that she would have been able to be about the past winter had it not been for the relief afforded by the drug.

My second trial was in the case of a man suffering with cramps in the calves, some lumbar pain on motion, and numb spots along the terminals of some of the sciatic-nerve branches. Iodid with colchicum afforded little relief; tincture of rhus (five drops to the dose) was added, and relief was speedy.

My third case was in a man, over fifty years of age, who had suffered with rheumatism at intervals for years, and whose urine, at the time of employing the drug, showed a specific gravity of 1025, with excess of urates. He presented himself for the treatment of an eczema of the scalp and backs of the hands. The promptness with which the case responded to treatment (rhus toxicodendron being given internally) led me to attribute the results largely to that drug.

In a number of other cases I have *thought* that I derived benefit from its use, and I continue to use it as an ingredient of my prescriptions for rheumatism.

In one case of irritable bladder I have tried the drug with negative results, but in this case the specific gravity of urine was but 1010; and although no tube-casts were found in the specimens, the other symptoms all pointed to the case being one of primary chronic nephritis.

In glancing over the various conditions for which the drug has been particularly recommended, we get some order out of the chaos. The stiffness, the cramps, the rheumatic pains, the incontinence of urine, the scaly and itching skin-diseases, and even the hemorrhoids and varicose veins, are so often the results and the accompaniers of the uric-acid diathesis that it is probably in the cases depending upon such a cause that the drug proves useful.

One other very significant fact occurs as a suggestion, and that is the well-known efficacy of the allied species "rhus glabrum" in the local treatment of pharyngitis of rheumatic origin.

Respectfully yours,

FRANK W. THOMAS, M.D.

GERMANTOWN, PA.

# THE TREATMENT OF CHOLERA MORBUS.

To the Editor of THE MEDICAL NEWS,

SIR: As in a great many parts of the country cholera morbus for the past few months has proved itself to be a disease of a most decidedly fatal character, I beg to suggest for the consideration of medical readers a treatment that, according to my observation, has universally been successful. I also wish to suggest that opiates, as they are generally used in this class of diseases, are, to a great extent, contra-indicated, and are frequently the indirect cause of fatal results. Only a few days ago I learned of a case, that of a young woman suffering with cholera morbus, which well demonstrated this fact. The pains and muscular contractions were very severe. Morphin was given and the doses repeated until relief was obtained. During the following day, as there was no pain, no more of the drug was administered, but the patient seemed to be sinking into a low septicemic state. During the second day she died, having rapidly developed symptoms of a ptomainemia. In this case there seemed to be no elimination, but consequent rapid formation and absorption of septic materials. Morphin was thought to be the cause of the stoppage of the channels of elimination. Such evidently is frequently the case in this class of diseases; ptomaines and like poisons are rapidly formed and absorbed, and in large quantities, as is evidenced by the conditions found: the extreme irritation of the alimentary canal, the rapidly destructive processes, the great amount of nerve-excitation, and the final collapse. Opiates should therefore be given with great caution, in as small dose as possible, and discontinued as soon as possible, because their tendency to arrest elimination from the body, especially through the kidney, is very decided. Many of us have heard physicians remark in speaking of a case of cholera morbus: "The pains and muscular contractions were so severe that I had to give several injections, each containing a large dose of morphin, before I could get any effect of the drug." If that physician had remained with his patient he would probably have found that after the pain (the antidote for opium) had ceased, his patient was in a condition of profound opium-poisoning, with tightly contracted pupils, scanty urine, a dry mouth, and slowed respiration. Such a condition in itself would require several days for the patient to recover from.

The treatment I wish to suggest for consideration and more general use is as follows: In the acute stage of the disease, given an ordinary dose of morphin hypodermatically; if, after a short while, this does not have the desired effect, administer chloroform to partial or complete anesthesia; keep the patient in a restful state for a short time, and then with perfect quiet allow him to recover from the effects of the chloroform. The morphin will, by this time, have had sufficient time to take effect, and in combination with the condition of exhaustion,

will produce a state of ease or most frequently a peaceful sleep. Reaction will rapidly commence, profuse sweating, a changed condition of the entire system, and with a simple mixture of bismuth, mint, etc., the patient goes on to complete recovery. On the day following the attack, the lower bowel should be washed out by means of an enema consisting of a pint or a quart of warm water containing ammonium chlorid 3j to the pint. The tincture of the chlorid of iron in 10 or 15 drop doses should be given three times daily following these attacks, as it seems to act in a most beneficial manner and frequently prevents relapse and inflammatory changes from taking place in the intestines. There seems to be no danger connected with the administration of chloroform in these cases, and the almost instantaneous relief given by it frequently shortens the disease and avoids a fatal termination, and, as by its use the spasmodic pains and muscular contractions are interrupted and the vomiting and purging checked, only a small amount of the opiate becomes necessary and the injurious effects of the drug are avoided.

Respectfully,

W. MAZYK MEMMINGER, M.D.

CHESTER, PA.

# MORE ABOUT STENSEN.

To the Editor of THE MEDICAL NEWS,

SIR: The variations in the spelling of this anatomist's name are due to the fact that he lived in various countries and wrote or corresponded in various languages. *Stensen* is the original form, as he was born in Denmark. In Italy he was called *Stenone*. The French form is *Sténon*; the Latin form is *Stenonius*, or *Steno*; his German contemporaries used both the Latin forms.

The form *Stenonius* often occurs, and almost always in the genitive case, as, for example, on his tombstone in the church of St. Lawrence, in Florence: "*Nicolai Stenonis . . . quidquid mortale fuit . . . hic situm est.*" Hence it is clear that *Steno* is a correct form, being the nominative, third declension, like *Cicero*, *Ciceronis*. If Stensen ever signed himself *Nicolaus Stenonis*, it must have been according to Danish usage, the word *filius* being understood, as if he would say: *Nicolas, son of Steno*. In English we should use the original Danish *Stensen*, or else the Latin *Steno* or *Stenonius*.

It may be worth while to add that Stensen was a remarkable man, and led a very eventful life. He ranks high not only as an anatomist, but also as a geologist and as a theologian. Born in 1638, he became a Catholic in 1667 during a visit to Italy. In 1672 he was Professor of Anatomy in the University of Copenhagen. Two years later he resigned that post, returned to Italy, and, in 1675, became a priest. In 1677 he was made bishop, and placed in charge of Catholic interests in Northern Germany. There he labored till his death, in 1686. His life was that of a saint, his zeal untiring, his charity limited only by his means, his self-mortification and fasting excessive—in fact, he seems as worthy of canonization as any saint in the calendar.

As a matter of truth, the doctors *do* need a patron saint.

Very respectfully,

R. J. DOHERTY, M.D.

CHICAGO, ILL.

## NEWS ITEMS.

*Dr. Vignard* has been elected professor of anatomy at the University of Nancy.

*Dr. Tappeiner* has been elected professor of pharmacology at the University of Munich.

*Bayer* has been made professor extraordinary of gynecology at the University of Strassburg.

*Fr. Kraus* has been made professor extraordinary of internal medicine at Vienna.

*Paul Ernst* has been made professor extraordinary of pathologic anatomy at Heidelberg.

*Richard Neumeister* has been made professor extraordinary of physiologic chemistry at Jena.

*Podwysotski* has been made ordinary professor of general pathology in the University of Keiff.

*Oscar Loew*, of Munich, has been called to Tokio to assume the professorship of botany in the University.

*V. Noorden*, assistant at the second medical clinic at the Charité at Berlin, has received the title of professor.

*Mitropolski* has been made professor extraordinary of special pathology and therapeutics in the University of Moscow.

*Herman Oppenheim*, formerly assistant in the department for nervous diseases at the Charité at Berlin, has received the title of professor.

*The Tri-State Medical Society of Alabama, Georgia, and Tennessee*, will hold its fifth annual meeting at Chattanooga, October 17th, 18th, and 19th. An interesting program is in process of preparation.

*The Southern Surgical and Gynecological Association* will hold its annual meeting at New Orleans, on November 14th, 15th, and 16th. Members of the medical profession are cordially invited to attend. A successful meeting is anticipated.

*Professor J. Sommerbrodt*, well known for his work upon sphygmography and for the construction of a sphygmograph with regulable pressure, and for his work upon the treatment of tuberculosis with creosote, died on August 14th, at Breslau.

*A New Medical School for Boston.*—The trustees of Tufts College have decided to establish a medical department, to be located in Boston and to be opened during the current session to both men and women. Dr. Albert Nott is the dean and Dr. Charles P. Thayer the secretary.

*The New York Medical Association* will hold its Tenth Annual Meeting on October 9th, 10th, 11th, and 12th, 1893, at Mott Memorial Hall, in New York City. The program includes the following addresses, papers, and discussions:

Address of welcome by the Chairman of the Commit-

tee of Arrangements, Dr. John G. Truax; address by the President, Dr. S. B. Wyllie McLeod; address, "The Medical Work of the Association during its First Decade," by Dr. John Shrady; address: "The Surgical Work of the Association during its First Decade," by Dr. Stephen Smith; "Report of Eight Cases of Placenta Praevia," by Dr. Zera J. Lusk; "Penetrating Wound of Anterior Fossa Through Orbital Plate of Frontal Bone—Recovery," by Dr. Zera J. Lusk; "The Treatment of Epithelioma and the Cancroid Ulcers by Topical Application," by Dr. Nelson J. North; "Prevention of Disease," by Dr. James G. Porteous.

"Lesions of the Pleura," to be discussed by Drs. John Shrady, Frank W. Ross, William McCollom, Edward F. Brush, J. Blake White, John G. Truax, M. K. Hogan, and Charles A. Leale; "The Surgical Treatment of Pulmonary Cavities," by Dr. N. P. Dandridge, of Cincinnati; "Remarks on Fermentative Dyspepsia," by Dr. Austin Flint; "Open Treatment of Tuberculous Diseases of the Joints," by Dr. T. M. L. Chrystie; "Bloodless Amputation at the Hip-joint," report of cases operated on by the author's method, by Dr. John A. Wyeth; "Report of a Case of Osteotomy of Both Femora for the Relief of Deformity following Ankylosis of the Hip-joints," by Dr. Reginald H. Sayre.

Address: "The Obstetric and Gynecologic Work of the Association during its First Decade," by Dr. George Tucker Harrison; "Rare Forms of Gout and Rheumatism," by Sir James A. Grant, of Ottawa, Canada; "Treatment Often Indicated after Trachelorrhaphy," by Dr. William H. Robb; "R," by Dr. Henry D. Didama; "Ten Years' Experience in the Treatment of Cataract," by Dr. Alvin A. Hubbell; "The Treatment of Enteric Fever," by Dr. Gustavus Eliot, of New Haven, Conn.; "Voluntary Commitment of the Insane to Asylums," by Dr. W. D. Granger; "Surgical and Pathologic Memoranda," by Dr. Donald McLean, of Detroit, Mich.

"The Treatment of Appendicitis," to be discussed by Drs. Frederic S. Dennis, R. N. Cooley, Donald McLean, W. S. Tremaine, Joseph D. Bryant, and John W. S. Gouley.

"The Male Catheter, with Some Observations upon the Proper Mode of Introduction into the Bladder," by Dr. Douglas Ayres; "Researches on the Efficacy of Vaccinia after Typhoid Fever," by Dr. William Finder, Jr.; "Reflections on the Need of Close Observation of Disease and on the Value of Hygienic Therapeutics," by Dr. H. Ernst Schmid; "Unique Case of Traumatic Tetanus, with Generalization—Recovery," by Dr. John G. Orton; "A Case of Puerperal Blindness," by Darwin Colvin; "A Plea for the Non-operative Method of Treating Dysmenorrhea, Pelvic Inflammation, and Pelvic Abscess," by Dr. T. J. McGillicuddy; "An Additional Note on Nephrotomy and Nephrectomy," by Dr. E. D. Ferguson; "Fifty Operations for Laceration of the Cervix Uteri," by Dr. J. B. Harvie; "Brief Comments on the Materia Medica, Pharmacy, and Therapeutics of the Year ending October 1, 1893," by Dr. E. H. Squibb.

## BOOKS AND PAMPHLETS RECEIVED.

*Pachymeningitis-myxedema.* By Samuel Wolfe, M.D. Reprinted from the American Therapist, 1893.

*Inguinal Hernia in the Male.* By Henry O. Marcy, A.M., M.D., LL.D. Pamphlet, 1892.